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CASE REPORT

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Psychodynamic therapy for adverse childhood experience in a hospitalized girl with attention deficit hyperactivity disorder

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Abstract: Child abuse and neurodevelopmental disorders are serious social issues in Japan. Abused children may present with symptoms similar to attention deficit/hyperactivity disorder (ADHD), such as increased impulsivity and difficulty concentrating. It is also known that children with ADHD are more likely to suffer from maltreatment, which can lead to psychiatric symptoms such as low self-esteem, depression, and defiant, challenging attitudes. Child psychiatric treatment needs to take both perspectives, childhood adversity and neurodevelopmental disorders, into account. In this case (A), there was a history of impulsive challenging behavior; in addition to the ADHD symptoms, the abusive upbringing from an early age had resulted in increased aggression, psychological damage, and low self-esteem. The abusive mother was also a competitor to her and was vulnerable and unable to present a healthy femininity to her. She entered adolescence without sufficient support from her mother before puberty. The ambivalence of dependence and rebellion extremely increased, and the problem manifested as withdrawal. In the treatment, while setting limits, positive evaluations of the positive aspects were actively communicated. Her therapist was particularly aware of becoming a part of her ego function different from her mother. A's challenging behavior was gradually reduced, and she was able to develop the right self-image. This is a case in which the structure of the hospitalization enabled the work of limiting the patient while protecting and accepting her. Clinical serious issues such as withdrawal, defiant challenging behavior, and symptoms of hyperactive impulsive inattention in adolescents require consideration and response to background adversity experiences and child abuse factors.

***Keywords*:** inpatient, child, child abuse, ADHD

Introduction

In Japan, several social issues exist, including the lack of child psychiatrists and child psychiatric wards as well as the rapid increase in the prevalence of child abuse. The prevalence of attention deficit/hyperactivity disorder (ADHD), which is one of the most common neurodevelopmental disorders, as well as autism spectrum disorders, is estimated to be 7.2% (*1*). Individuals with ADHD exhibit hyperactivity, impulsivity, and inattention. Furthermore, this condition is complex and involves a combination of biological and psychosocial factors, *e.g.*, increased impulsivity and irritability due to attachment difficulties and possible mood disorders, such as severe emotional dysregulation (*2,3*). Close attention should be paid to environmental factors (*e.g.*, bullying, teacher reprimands, parental abuse) that may influence the symptoms of ADHD. For example, of the 878 patients prescribed the three anti-ADHD medications Methylphenidate, Atomoxetine, and Ganfacine, 43 (4.9%) had used all three medications, indicating that children with severe ADHD symptoms, autistic features and child-parent violence are more likely to experience all three during their treatment have been found to be more likely to experience three medications during treatment (*4*). Therefore, it is crucial to assess the background of ADHD symptoms and, in doing so, consider interventions for these background factors.

The 5th edition of the Guidelines for the Diagnosis and Treatment of ADHD in Children was published in 2022 (*5*). It recommends focusing on psychosocial treatment rather than pharmacotherapy and states that the treatment goal "should not be the complete elimination of the three main symptoms of ADHD, but rather the improvement of the vicious cycle of maladaptive conditions at school and at home with the improvement of these symptoms and the ability to accept ADHD symptoms as personality traits of individual". The goals of ADHD treatment are the development of moderate self-esteem through the acceptance of the disorder and the development of an adaptive personality based on ADHD characteristics. An appropriate psychosocial treatment should be provided on the basis of thorough understanding of these treatment goals. After providing psychosocial treatment, minimal medication should be considered.

We have experienced an inpatient treatment of a girl with ADHD who had been brought up in an abusive environment. Children that have been abused can exhibit increased hyperactivity and impulsivity, which are very similar to the primary symptoms of ADHD. Simultaneously, children with ADHD are likely to be exposed to abusive parenting, *e.g.*, harsh reprimands, because of their symptoms. As a result, they tend to show psychiatric symptoms, such as damaged self-esteem, further deterioration of impulse control, and increased aggression.

Consent for the presentation of the case was obtained from the patient and their families.

Case Report (A)

Basic characteristics

To ensure anonymity, some parts not related to the treatment were modified. For the western calendar year, the year of admission was set as X, with ± denoting the number of years before and after.

The basic characteristics of this case are as follows: *i)* Age: 14 years old; *ii)* Sex: Female; *iii)* Main complaint: hyperactivity, impulsivity, inattention; *iv)* Medical history: No history of psychiatric illness; *v)* Family structure: A's mother was a secondary school graduate and a housewife. She suffered from dissociative disorder and depression. She had been neglected, raped, got pregnant at 15, and had an abortion. In addition, she had been arrested for using methamphetamine. She was constantly verbally abusive and violent toward A. She repeatedly cut her wrist and overeat and vomits in front of A. On the other hand, A's stepfather was a high school graduate and a carpenter; he was sometimes violent toward A. A has two younger sisters from her mother and stepfather.

Growth and current medical history

No major problems in perinatal or infantile development. There was domestic violence from the father to the mother, and parents divorced when A was 2 years old. She was first seen at our clinic in year X-8 (age 6, 1st grade). In junior high school, she stopped attending school and became violent at home. She was voluntarily admitted to our clinic in April, year X (age 14, 3rd grade junior high school).

Psychological test results: When A was 14 years old, she took the Wechsler Intelligence Scale for Children, Fourth Edition, and obtained the following scores: Full-Scale Intelligence Quotient, 124; Verbal Comprehension Index, 103; Perceptual Reasoning Index, 122; Working Memory Index, 100; and Processing Speed Index, 132.

Child and adolescent psychiatric ward: The child psychiatric ward is located in a general hospital. It is an open ward with 45 beds. It has 8 four-bed rooms and 13 private rooms for children from the upper grades of primary school to the third grade of junior high school. The children can attend school at the hospital.

Assessment and treatment plan at the time of admission: At the time of admission, there was no information regarding abuse by the stepfather and mother, or regarding the mother's difficult upbringing and mental state. We considered this to be a case of repeated maladjustment due to ADHD symptoms and difficulties in family relationships leading to the patient's non-attendance at school. The treatment plan was to provide the patient and parents with psychoeducation about ADHD and to reintegrate A into the same generational group. A female child psychiatrist became A's therapist, and a female nurse became A's charge nurse.

Pharmacotherapy: Methylphenidate hydrochloride 36 mg/day.

Treatment

Phase 1 (April – August, year X)

A spent a lot of time fussing and talking aggressively to other children she had never met before. She did not attempt to interact much with adults. Her mother refused to take her home on holidays or visit her. She continued to cope with her feelings of loneliness without acknowledging them and gradually became isolated from her friends. She always had a conflict with other children. However, she usually helped the staff in minor situations and calmed other children who were acting out in the ward. Her therapist told A that there was a good side to her and that she was repeatedly trying to deal with her negative feelings in a manic way, which was extremely hurtful. Then, A began to show signs of dependence on the therapist, such as quietly approaching her when she was anxious. A said, "I do not like girls. Girls are vulnerable and fragile. They irritate me when I see them. They are different from me". She often wore men's clothes. Once, when the therapist reported to A's mother that she was having a good time on the ward,

she expressed her rejection of A even more strongly than before. The mother told the therapist that her own mental health was very poor; she had been abused since childhood; she hated A, who had repeatedly caused her problems; and she wanted a life without A. A's mother, who had survived difficult circumstances, was unable to deal with her own childhood experiences and turned against A.

Phase 2 (August, year X – January, year X+1)
We repeatedly lost contact with A's mother, and she had refused A's temporary return for holidays and cancelled interviews without prior notice. During meetings with her therapist, A avoided important topics and instead repeated physical complaints. There was an increase in challenging behavior, such as repeatedly visiting other rooms to compete with rival girls and making noise in the corridors at night. The therapist understood that A's problematic behavior was a manifestation of her own pain, and she repeatedly told her she was concerned about her. Gradually, A began to talk more about her feelings. However, shortly after the meeting, it was decided that she would not be allowed to leave her room at night in order to deal with the problem of trespassing in other rooms. As this happened right after we had talked about confidentiality, A said, "I don't think I can talk to you anymore". She stopped talking about anything during the interview. The therapist was so preoccupied with the superficiality of the problem that she felt helpless, as if she had missed something important. In November, A was not speaking to her therapist and was continuing to lose weight. Thus, the therapist decided to increase the frequency of interviews to twice a week and give her a private room to let her know that we cared about her and wanted to protect her. When the therapist told her this, she looked relieved and nodded her head with tears in her eyes.

In December, influenced by the removal of behavioral restrictions for hostile girls in the same year, she continued leaving her room without permission and making noise in the ward at night. Her therapist repeatedly told her to communicate her feelings and thoughts to the therapist instead of expressing them through behavior, but the conversation continued with name-calling and silent confrontations that lasted dozens of minutes and exhausted even the therapist.

The ward staff discussed the issue and decided that the nurse should invite A to go for a walk every day and create opportunities for the adult and A to engage with each other. A refused, saying "walking is such a hassle, I'll never go". However, she looked happy every time she was invited.

The same situation continued in our meeting. However, she did not refuse the meeting and repeated the same exchange twice a week. A gradually began to go for walks and complain about her therapist and family only on days when the charge nurse invited her. Again, her therapist reminded her of deadlines and commitments and urged her to stick to the rules. When the therapist praised her attitude and efforts, she looked good and confident.

Phase 3 (February – March, year X+1)
Although she continued showing problematic behaviors and experienced restrictions from her therapist on several occasions, she did not rebel as much as before. A's mother, a high school dropout and a secondary school graduate, was reluctant and critical of her support for A going to high school, but A decided to enroll in a correspondence high school and always attended the first period of her class at the hospital to practice commuting to school.

She strongly objected to the idea of all the girls dancing together in beautiful skirts at the farewell party in the hospital ward and was very insistent that she would not participate. However, through communication with the charge nurse and her therapist, she eventually decided to attend and was able to dance with a smile on her face. She even hesitated to take off the costume immediately after the party. After leaving the hospital, she went to a correspondence school and worked part-time. She sometimes forgot to go to the outpatient clinic or argued with her mother, but she found her place outside the home.

Discussion

Phase 1 (April – August, year X) included psychological treatment, which involved relationship building and understanding pathological conditions. There was a major problem in A's family: she had no experience of emotional acceptance. She had no choice but to express her negative feelings through aggression and impulsive challenging behavior. It was important for the therapist to acknowledge A's feelings and positive aspects and to present an image of women other than A's mother.

Phase 2 (August, year X – January, year X+1) included very important clinical sessions to help with acceptance and limits owing to her impulsivity and low self-esteem. When her therapist set the limits, she would violently rebel and direct her strong aggression toward her. The limits were not an attack or punishment on A but were intended to protect her from being hurt by her challenging behavior. Several studies have demonstrated that low self-esteem resulting from childhood adversity experiences has a significant impact on children's lives (*6,7*). A was abused by her family and, as a result, did not develop self-esteem and emotional regulation. Treatment staff continued to show A acceptance while restricting her. Thus, it was necessary for her to experience controlling her own impulsivity through interaction with treatment staff and other children in the controlled environment of the inpatient treatment. From the perspective of family therapy, the first step was to

ask the mother about her own upbringing and symptoms. The therapist told her that she also wanted to support and help her and proceeded to adjust the environment while listening to her story.

Phase 3 (February – March, year X+1) involved gaining a modified emotional experience through inpatient treatment by establishing a bilateral relationship with the attending her therapist and interacting with peers and teachers in the inpatient classrooms. A had an ambivalent attitude toward a group therapy including junior high school girls. When she was asked to dance with a group of girls at the farewell party at the end of the school year, she showed both a vehement refusal and a desire to join. A's therapist team encouraged her to participate because they felt that it was important for her to learn to accept her own female identity. She was able to work with the female staff and seemed to accept them as a female role model who were different from her mother. Eventually, she danced in her high school uniform. At the end of the meeting, she gave a great speech as a representative of the graduating class in her uniform and was discharged from the hospital in March, year X+1.

Conclusion

In this case, there was a history of impulsive challenging behavior; in addition to the ADHD symptoms, the abusive upbringing from an early age had resulted in increased aggression, psychological damage, and low self-esteem. The abusive mother was also a competitor to her and was vulnerable and unable to present a healthy femininity to her. A entered adolescence without sufficient support from her mother before puberty. The ambivalence of dependence and rebellion extremely increased, and the problem manifested as withdrawal. In the treatment, while setting limits, positive evaluations of the positive aspects were actively communicated. The staff were particularly aware of becoming a part of her ego function different from her mother. A's challenging behavior was gradually reduced, and she was able to develop the right self-image. This is a case in which the structure of the hospitalization enabled the work of limiting the patient while protecting and accepting her.

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Conflict of Interest: The authors have no conflicts of interest to disclose.

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