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Attention deficit hyperactivity disorder (ADHD): An affect-processing and thought disorder?

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In the literature on child and adolescent psychoanalysis attention deficit hyperactivity disorder (ADHD) is described as complex syndrome with wide-ranging psychodynamic features. Broadly speaking, the disorder is divided into three categories: 1. a disorder in early object relations leading to the development of a maniform defence organization in which object-loss anxieties and depressed affects are not worked through via symbolization but are organized in a body-near manner; 2. a triangulation disorder in which the cathexis of the paternal position is not stable; structures providing little support alternate with excessive arousal, affect regulation is restricted; 3. current emotional stress or a traumatic experience.

I suggest taking a fresh look at ADHD from a psychoanalytic vantage point. With respect to the phenomenology of the disorder, the conflict–dynamic approach should be supplemented by a perspective regarding deficits in α-function as constitutive for ADHD. These deficits cause affect-processing and thought disorders compensated for (though not fully) by the symptomatology. At a secondary level, a vicious circle develops through the mutual reinforcement of defective processing of sense data and affects into potential thought content, on the one hand, and secondary, largely narcissistic defence processes on the other. These considerations have major relevance for the improved understanding of ADHD and for psychoanalytic technique.

Keywords: attention deficit hyperactivity disorder (ADHD), thought disorder, affect processing, triangulation, narcissistic defence

Attention deficit hyperactivity disorder (ADHD) is the most frequent psychiatric diagnosis in childhood and adolescence. Whereas the description of the symptoms for what we refer to as ADHD has remained remarkably constant over 150 years (cf. Griesinger, 1845; Still 1902), everything else about this disorder continues to be the subject of discussions marked by fierce controversy.

The first controversy concerns the aetiology of symptoms. According to a biological–medical model in which genetic factors are emphasized, ADHD is perceived, on the one hand, as a transmitter disorder in the dopamine metabolism, possibly also in the noradrenalin and serotonin metabolism of the brain, and on the other hand as a genetically determined extreme variation of temperament. There is empirical evidence supporting both positions. Genetic studies have been able to show that the incidence and degree of an

ADHD have to be interpreted rather as occurring across a normal distribution in the population than as the consequence of a genetic defect in the narrower sense. On the other hand, genetic polymorphisms of the dopamine system are described which are associated with ADHD (Banaschewski *et al*., 2010; Faraone *et al*. 2005; Levy *et al*., 1997; Tannock, 1998). They only slightly raise the risk (of ADHD developing) and are very widespread in the population (Smith *et al*., 2009). The theoretical models of the connection between a transmitter disorder and ADHD are to date contradictory and a matter of controversy. Discussion is still ongoing about the influence of genetic causes, organic damage and traumatizations in a patient's history on the structure and building up of neuronal networks, particularly those in the frontal cortex and in the striatum (Gensler, 2011; Günter, 2008; Zabarenko, 2011).

On the other hand, there is abundant evidence on the relevance of psychosocial factors which cause ADHD to arise. Christakis *et al*. (2004) showed that the risk of attention deficit disorders in school-age children increases by 10% per daily hour of television viewing before the age of 3. Various longitudinal and epidemiological studies were able to demonstrate that multiple regulation disorders in infancy and, even more so, psychosocial stress significantly increased the risk of a later development of ADHD (Becker *et al*., 2004; Hjern *et al*., 2010). A wide field of psychoanalytical and psychotherapeutic literature has consistently been concerned with the interconnection between symptoms, dysfunctional family relationships and typical inner conflict constellations in cases of ADHD (cf. among others, Berger, 1993; Bovensiepen *et al*., 2002; Bürgin and Steck, 2007; du Bois, 2007; Gensler, 2011; Häussler, 2002; Heinemann and Hopf, 2006; Leuzinger-Bohleber and Fischmann, 2010; Leuzinger-Bohleber *et al*., 2007, 2011; Seitler, 2008, 2011; Streeck-Fischer and Fricke, 2007).

A second controversy concerns the question of whether ADHD is in fact a nosological entity or whether more or less chance combinations of symptoms are being artificially bracketed under the one term. A nosological entity is characterized by uniform aetiology and symptomatology. In view of this definition the controversies over aetiology described above gain particular significance. What also remains unclear is to what extent ADHD can be regarded as a discrete illness or whether – above all, if accompanied by an anti-social disorder – it does not rather represent a risk factor for a developmental disorder.

Thirdly, the question of therapeutic possibilities is also a matter of highly controversial debate. The effect of amphetamine derivatives on hyperkinesis and attention disorder – an effect which should more appropriately be regarded as unspecific – has frequently led to conclusions of a biological aetiology of the disorder being too rapidly drawn. Re-analyses of the major MTA study, which is routinely cited as the most important reference, have made it clear that a superiority of treatment by medication over behavioural therapy methods (psychoanalytically oriented approaches to treatment were not even taken into consideration) was only shown with reference to the symptoms hyperkinesis and attention deficit disorder and not to the multiple comorbid symptoms frequently occurring in ADHD. The Cologne

Multimodal Interventions Study was even able to show a clear superiority of therapeutic over medication-based interventions (Conners *et al*., 2001; Döpfner and Lehmkuhl, 2002). On the other hand, the evidence for the effectiveness of behavioural therapy is also not so widespread and secure as it is occasionally represented (Ahrbeck, 2009). On the contrary, more and more doubts are emerging as to the effectiveness of certain intervention techniques, and evidence of positive long-term effects is not as yet really certain. In their multicentre NIMH study Jensen *et al*. (2007) found that in comparison to behavioural therapy positive medication effects were not maintained at the three-year follow-up.

As a result we have to assume that we are confronted with a complex set of problems suggesting a relatively delineable set of symptoms but in which many problems have not as yet been scientifically clarified. At the same time a new focus of interest has emerged regarding the effects of the acceleration in the pace of our lives, the impact of media culture and the way we are inundated with information. This brings about changes in our habits of perception, in the self-regulation processes connected to such habits and the management of attention, activity and impulsiveness. These are increasingly making important demands on the processes of upbringing and education of the young. To this extent one could regard attention deficit hyperactivity disorders as a paradigm for our times and for the development of the industrial societies of the West, and this may at least partly explain the popularity of the diagnosis (Timini, 2005).

Child psychoanalysis and ADHD

In this situation, with its mixture of unanswered questions and a seemingly simple and clear diagnosis, child psychoanalysis is in an awkward position. One way out of it seemed to be to question the existence of ADHD or at least cast doubt on its diagnostic validity (Gilmore, 2000). But such doubts – however well founded they may be as regards the diagnostic accuracy of the construct – are too easily misunderstood as a negation of the phenomenon itself with all the problems that this entails. Such a position is hardly appropriate in a situation in which there is a call for clear diagnoses and a desire for simple concepts for carrying out treatment given the emergence of the problem in massive numbers. The opposite approach has consisted in denying the effectiveness of psychoanalytically grounded methods of treatment (cf. Gilmore, 2000). A third position widely adopted in the clinical psychoanalytic literature was to concentrate on describing typical conflict dynamics which regularly appear linked to ADHD. This view, however, involved assuming the existence of a more or less circumscribed disorder entity, although, as described above, it does not as yet seem to be genuinely established either as regards a uniform aetiology or as regards clear ideas on its psychodynamics and pathogenesis.

For this reason I advocate understanding ADHD symptoms – on the plane of conflict dynamics – as a final confluence of earlier inner psychic conflicts of differing origins (cf. Leuzinger-Bohleber *et al*., 2011). In view of the obscurities described it would seem to me presumptuous to postulate

specific conflicts or even possibly quite specific points of fixation as the clear cause of the development of an ADHD. Nevertheless, given the status of research to date, I feel justified in outlining three main points in the psychoanalytic perception of ADHD.

ADHD as a defence formation in reaction to early disorders in object relations

Attention deficit disorders, impulsivity and psychomotor restlessness can be seen as defence formations against early traumatic experiences which the infantile ego was unable to process and integrate. These will have been formed at an early stage and become correspondingly cemented. Such experiences might be loss of the object, inconstancy in the experience of relations with objects, severe deprivation or other mal-developments in early dyadic relationships. Terminology may well differ but the underlying deep disturbance in the primary relationship, which cannot be sufficiently symbolized and is therefore organized in this near-to-body motor defence formation or in attention disorders, is described in relatively similar ways largely independent of the theoretical standpoint of the authors.

One can speak of a maniform defence in this context: the experience of intolerable pain, of fear of the loss of the object or of fear of persecution is warded off by substituting these more primitive forms of very near-to-body defence for processes of symbolization and mentalization. Stern (1998) depicted mechanisms which illuminated the way a maternal postpartum depression may be responded to by the infant in the development of hyperactive behaviour. Green (1983) described the effect of the 'dead mother' in dislocating the development of the child. Leuzinger-Bohleber *et al*. (2007) took up the infant's resulting feelings of guilt, phantasies of revenge and hatred directed at the primary object which found expression in the symptoms. From the view-point of ego psychology this constellation can be understood theoretically as the severe and early impairment of ego functions "brought about by the primary object's failure to contain and focus (center) attention". One of the most prominent problems arising from this is "the failure to learn to use symbolizations in order to express emotion, thus leaving imperative action as a prominent mode of avoiding being overwhelmed by unbearable feelings" (Sugarman, 2006, p. 238). From the perspective of object relations psychology, instability of inner object relations has developed and these then appear threatening, unreliable and persecutory or unavailable. Both perspectives make it clear that psychic processes of digestion and symbolization are replaced by symbolic equations (Segal), that a 'holding function' (Winnicott) or a containment and thus transformation of β-elements in α-elements (Bion, 1965) are insufficiently developed, or that mentalization and 'reflective function' (Fonagy and Target, 1998) are replaced by motor action and excitability. In her conceptualization of a 'second skin' formation related to a failure in the very early integration of parts of the personality, Bick described hyperactivity and what she called a "muscular type of self-containment" as substitutes for a faulty skin formation (Bick, 1968, p. 485). In a similar manner the connection between

ADHD and infant regulation disorders, and also between ADHD and the disorganized attachment type, can be regarded as the expression of unstable object relations and inner working models. It is assumed in the theory of attachment that there is a transgenerational handing-down of disorganization and/or a disorganizing interaction between the primary object and the infant. This position is in agreement with research on infancy and interactional psychoanalytic approaches (Brisch, 2002).

Disturbances in triangulation

Clinical experience shows how difficult it is for families who have a child with ADHD to occupy the triangulating paternal position in a stable form in order for it to take effect in their interactions. Frequently, the failure of supportive structures alternate with states of excessive excitation into which mother and child fall – it is most often the mother who is involved – so that in these stormy passages the regulation of affects can be lost. But children with hyperactivity, impulsiveness and attention disorders have a more than average need of such supportive structures. Thus, irritability in the child interacts with insufficient containment in the family relations to create a vicious circle.

This observation led to a more careful examination of how the father representation is anchored in the child's inner world. The frequently observed psychic or physical absence of the father (Heinemann and Hopf, 2006; Widener, 1998) leaves children, and above all boys, without the means of internalizing a stable boundary-setting agency and to regulate themselves by orienting their actions to such a model. Our own researches point in the same direction. In children with ADHD the boundary-setting father representation in the child's experience of itself was significantly more marked after treatment with methylphenidate (Koch, Straten and Günter, 2009). We saw this correspondence between the alleviation of the severity of symptoms and better father representations as a complex interaction not yet fully understood. Instead of having a stable, boundary-setting father representation such children may take over sadistic–violent aspects of the father – as in an identification with the aggressor – and reproduce them in their relationship to the mother. The hyperactivity then expresses the insoluble conflict between a still binding early attachment to the mother and the wish to break away and become autonomous (Heinemann and Hopf, 2006; Streeck-Fischer and Fricke, 2007).

These conflict dynamics take place in principle at a more mature stage of development than those described in point 1 where it was a question of the early disturbance of the formation of inner agencies. Disturbances in triangulation can explain the clear differences in frequency of incidence of ADHD between boys and girls relatively well. Explaining this gender difference in the frequency of the early disorders described in point 1 requires taking later re-workings of these experiences into consideration. In the course of later oedipal re-working these disorders in girls are generally organized in internalizing symptoms whereas the defence organization in boys shows a tendency to externalization. This kind of defence organization, which is what disorders in triangulation are about, is fairly easy to identify

in manifest behaviour whereas the warding-off of early paranoid and object-loss fears, such as are described in point 1, only become accessible and amenable to treatment in the course of in-depth therapeutic work.

Emotional stress and traumatic experiences

In psychodynamic terms a third group can be defined in which inattention, hyperactivity and impulsivity are determined by emotional stress or traumatic experiences such as a severe illness, the death of a parent, maltreatment or deprivation occurring concurrently or during early stages of psychosocial development (Szymanski *et al.*, 2011). Conway *et al.* (2011) reported a high comorbidity of trauma and ADHD and concluded that: "Experiences of chronic adverse situations during childhood, also referred to as complex trauma, cannot be extricated from ADHD symptomatology and is strongly correlated with behavior that is common among children who have deficits in … mentalization" (p. 60). Strictly speaking, such children should not be diagnosed with ADHD since in these cases the symptoms can be explained by the stress experienced. In practice today, however, in the routine diagnosis, this clear restriction, although it is prescribed in ICD–10, is frequently and rather casually ignored and a diagnosis of ADHD is given purely on the basis of the symptoms. In this process emotional strain is often overlooked. It is therefore important to see this group as separate since the symptoms are a direct result of stress. When the immediate adverse effects diminish then hyperkinesis, impulsivity or attention deficit often recede at least if a caring environment is provided for the child. These symptoms are not organized so powerfully in a cemented defence formation as is the case in the other two groups.

To summarize, on the level of conflict organization, attention deficit hyperactivity disorder appears from the perspective of psychoanalysis as a phenomenon which can have different roots. Probably the symptoms should be regarded less as a specific disorder entity, precisely defined even in conflict dynamic terms, and more as the final confluence of a limited range of reactions to different impairments.

ADHD: An affect processing and thought disorder?

There are clear difficulties here in formulating the core problems of ADHD on the basis of conflict dynamics, and there is definitely a wide divergence in individual cases to which the grouping around basic structures sketched above does not do real justice. From the late 1990s on these problems in conceptualizing ADHD in psychoanalytic terms have given rise to a body of literature which emphasize the "disruption in very basic ego functions" (Gilmore, 2000, p. 1286, similarly Migden [1998] for dyslexic children with ADHD symptoms). Gilmore pointed out that: "The inconsistency and variabilty of the integrative, organizational, and synthetic functions of the ego are really the problem" (2000, p. 1287). This perspective has resulted in certain modifications of technique in child analysis or, to be more precise, has led to a somewhat different focus in the analysis of children with ADHD:

> … the child analyst does more of the work to organize self-states, integrate the transference distortions into a coherent, historically meaningful narrative, and synthesize the appearance of defense with the dissociated affects and drive derivatives that are often at the same time transparent and rigidly disavowed. These interventions, applied with persistence and tact, directly ameliorate the core disturbance in the disorder known as AD/HD.
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> (Gilmore, 2000, p. 1290)

Orford (1998), summarizing in a similar way her technique as "substituting higher cortical activity for the habitual activation of unconscious, and more primitive subcortical responses" (p. 264), saw successful interventions as involving an experience of regulation of chaos for the ADHD child. Jones (2011) regarded ADHD as resulting from a "reality sampling deficit" and suggested an adaptation of treatment technique "with an emphasis more on process than content and links to mentalization-based therapy" (p. 73), suggesting that the analyst should present himself for contact and cathexis in a more pervasive manner to support the development of higher order representation of instinct derivatives in the child. These approaches have encouraged me to rethink the possible difficulties which underlie ADHD from a psychoanalytic perspective.

I started first of all with the phenomenology of the disorder on which there is widespread agreement. In the foreground there is the disorder affecting attention and in many cases also controlling functions. Then, on the one hand, on the level of more or less conscious or preconscious patterns of object, interaction and affect representations (which in the empirical research tradition are called 'mental representations'), there is a tendency to avoid or interrupt emotionally meaningful contact and to maintain affective neutrality. On the other hand, corresponding to impulsivity, a lack of inhibition and of limits can be observed in these mental representations (cf. Koch et al., 2009). This is described in the literature on behavioural therapy in very similar terms. On the basis of this very general agreement the idea suggests itself that ADHD is a malfunctioning of thought and affect processing: sense data and affects, that is to say β-elements, cannot be digested in appropriate ways to form thoughts and so be transformed into α-elements. Instead they shoot directly into impulses and thus into motor restlessness forming the symptoms of impulsivity and hyperactivity. What seems even more fundamental is the resulting disorganization of thinking, in the sense of an incapacity to orient attention to inner representations and so achieve coherence and flexibility in thinking and acting. Instead distractability is predominant: the children cannot relate two thoughts or two activities to each other; in thinking they jump from one thing to another and show inadequate development of mentalization capacities.

All of this leads to avoidance or breaking off of contact with others and also to affective neutrality, at times even to an affective stupor as opposed to an appropriate processing of affect, in the sense of α-function. From this perspective perseverative tendencies, which are often observed, could be regarded an attempt to substitute pseudo-representations for the missing α-function to

a certain degree. Such pseudo-representations might be established through the constant exact repetition of thought and action schemata.

If, as I suggest here, one sees the core of the inner psychic problems in ADHD in a thought disorder – or, more precisely, a disorder in the processing of sense data and affects needed to form thinkable content, i.e. a disorder of α-function, the following question arises. In what way does ADHD differ from a schizophrenic psychosis, in which there is also a severe impairment of α-function? Phenomenologically, the latter produces very different consequences. I see the difference above all in two areas.

1 In psychosis elements that cannot be integrated, elements that have contradictory qualities, are rendered less threatening through processes of fragmentation. This leads to the typical disintegration of ego functions (Günter, 2000).
2 In psychosis bizarre objects are formed: fragments of the personality are expelled through projective identification. In this way the perceptual apparatus frees itself of conscious awareness of inner and outer reality:

> In the patient's phantasy the expelled particles of ego lead an independent and uncontrolled existence, either contained by or containing the external objects. They continue to exercise their functions as if the ordeal to which they have been subjected had served only to increase their number and provoke their hostility to the psyche that ejected them. In consequence the patient feels himself to be surrounded by bizarre objects…
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> (Bion, 1956, p. 47)

Both aspects lead to a restriction of control over reality which is characteristic of psychosis. By contrast, in ADHD, the restricted α-function of the psychic apparatus is not responded to with a fragmentation and the formation of bizarre objects (with respect to the latter I disagree with Salomonsson's opinion [cf. Salomonsson, 2011]) and, so to speak, pathologically compensated for (cf. Günter, 2009), but, here, unprocessed affects are directly channelled into impulsive actions. They lead to disorders in narrative coherence and to the demolition of identifications with complex inner objects (in the sense of object–action–affect representations). When they would demand the integration of contradictory elements, perceptions which are necessarily linked with affect cannot be integrated by the restricted α-function. Instead they are responded to with perserverative actions and affect schemata and lead to 'jumpiness' in thought, distraction and problems in directing attention.

To make things worse, severe relationship and interaction disorders frequently occur in ADHD children and lead to marked secondary neurotic processes. As a result, unconscious conflict constellations are further inflamed and, typically, depressed and aggressive affects build up which are accompanied by marked self-esteem problems, susceptibility to narcissistic wounding and disappointed rage. That kind of oedipal conflict constellation evolves besides what I see as core problem in ADHD described above and is addressed psychoanalytically mainly in terms mentioned under point 2 above. In the end this can produce a vicious circle. Even more than in the

case of a healthy person, such neurotic 'derailing' would demand an intact α-function for the individual to be in a position to limit the damage. Instead the set of problems is exacerbated from two directions: on the one hand, psychic regulation capabilities are even further derailed; cemented neurotic illnesses emerge and, as a third factor, additional impairments of α-function and of ability to mentalize appear.

Three forms of defence organization can be observed in this complex interaction between primary thought disorder and secondary neurotic development:

1 A narcissistic–maniform defence coupled with anti-social grandiose fantasies and aggressive–expansive symptoms. There may be increased impulsivity or the patient may develop a lasting narcissistic personality.
2 A second defence organization in such developments founded on ADHD is marked by depressed traits, signs of social anxiety and low self-esteem, i.e. narcissistic fragility. Here in the course of a vicious circle, described above, an inadequate processing and metabolization of depressed–anxious affects may develop (cf. Seitler, 2008, 2011). At first glance it seems that girls tend more to this form of defence organization. But on closer examination a similar layer of unconscious organization can regularly be detected in boys – under the first layer of narcissistic–maniform defence.
3 A third type is best described in the words disorganised–dissociative: these most clearly approach the fragmentation processes in psychotic developments. In these the unprocessed raw emotional data and raw sense impressions, i.e. β-elements (Bion 1962a,b), are organized in a makeshift way. This type is characterized by a chaotic self and relationship organization and 'jumpiness' and shows parallels to the disorganized type described in attachment theory.

This kind of perception of the core problem of ADHD, oriented as it is to Bion, has considerable consequences for treatment techniques. On this foundation the first important step would be to work on getting the impaired α-function, the mental apparatus itself, to work again before any interpretations of neurotic conflicts in the stricter sense can be effective.

Case study

Nine year-old Lukas was presented to me after he had been in analytical psychotherapy in a twice-weekly rhythm for two years. When he started school he had shown considerable difficulties in social integration and a pronounced attitude of defiance from the start. During lessons he would just twirl round and round on a swivel chair, for instance, and was at times intractable to the point of outright refusal to do what he was told. He never did any homework and he was moody. He had hardly any social contact in the class and felt isolated. Since the third grade increasingly aggressive traits were manifesting. He repeatedly came out with distinctly destructive fantasies and got up to nothing but mischief in class so that the situation was becoming close to intolerable for the school. Since alongside dyslexia he had been diagnosed with a 'hyperkinetic conduct disorder' (ICD–10: F90.1)

he was referred to me over the question of a medication-based treatment to accompany the continuing analytical treatment in order to prevent his imminent expulsion from school. Marked narcissistic and depressed symptoms had also been diagnosed.

The family moved into the neighbourhood of our hospital which meant that his therapy was broken off after nearly four years. They asked me to take up his therapy. By this time he was 10 years old and in the fifth grade at *Gymnasium* [grammar school] and the parents had great hopes of his being able to stabilize. However the situation at school escalated again after he broke his arm just after the beginning of term and was considerably handicapped by this for a number of weeks. After this, at times he would utterly refuse school work. He would whisper blood-chilling threats to his schoolfellows which led to the school threatening to expel him. At home too he was seen as extremely defiant or evasive. The only thing he wanted to do was play on the computer. This led to angry arguments with his father, who commented that he had been very much the same as a child. So I decided to offer Lukas a high-frequency psychoanalytical treatment. He was then 11 years old.

At first this analysis led to a relatively rapid stabilizing of the school situation and to some easing of the situation in the family although that still remained pretty difficult. With me, although he seemed cooperative, Lukas was emotionally fairly inaccessible except in the violent, aggressive fantasies which he described in a provocative tone. A pronounced narcissistic defence had formed and this was accompanied by a negative self-image, a defiant attitude and emotional inaccessibility. Nevertheless, he nearly always came to his sessions on time and liked coming.

It was hardly ever possible to offer interpretations of his unconscious conflicts over long periods in his treatment particularly since such attempts on my part seemed to have little effect on him. The priority was to work on the mechanisms with the aid of which Lukas was seeking to compensate for his disorders in thinking and affect processing. At the same time these solutions were driving him into almost complete emotional and social isolation. Over a very long period Lukas was incapable of unstructured play in the therapy sessions – and presumably outside them, too.

I will now outline a few points which dominated the way the sessions went and which cast a light on the extent of the disorder in his ability to deal with relationships, thought and affects.

Computer games

Lukas implored me to let him play computer games and so we made an agreement that for 20 minutes in every session he should be allowed to use my computer to play games freely accessible on the internet. He would however have to accept that, although I would not be playing with him, I would participate in one way: I would want to know what it was all about and I wanted to stay in a kind of conversation with him while he played. He usually chose some kind of shooting game. After one and half years of treatment he more often chose to play games requiring a certain dexterity in

handling the mouse to achieve his goal. I would sit on the arm of a chair behind him, following his every move closely, and I forced him to explain or at least try to explain what the point of the game was. It was uphill work; I usually had to drag it out of him and his answers were often only a few words squeezed out between moves. Nevertheless this led to a rudimentary form of social communication while all the time he was in danger of sinking into the virtual world of the game as he presumably did when outside our session.

Another thing I tried to do was to keep naming affects whether these were aggressive affects, anger over a failure, disappointment or moments of triumph over an opponent, or admiration of his skill. It was painfully slow work and there was often very little resonance on his part which in turn in my countertransference made me feel as if I were incapable of doing any genuinely analytic work. The process became more alive when he wrangled with me over being allowed to extend the 20 minutes. This soon became a game in which practically every time he negotiated with me to have a further 10 minutes, but in return he had to agree that in the next session he would not be able to play on the computer at all. His wit, creativity and skill in trying to get the better of me in order to gain one or two extra minutes were met however from my side with a boundary set in stone and he accepted this every time despite all his efforts to push it back.

Monkey wrestling

One of his favorite and most frequent 'games' was to tie up my monkey glove puppet really tightly, or bang it on the table or against the door so violently that I was afraid its eyes would pop out. He would throw it against the wall or onto the floor, leap on it like a wrestler and box it in the belly with his elbow etc. He was capable of filling the entire session with this perseverative-like game. The aggressive–destructive comments he made while playing this were stereotyped and spoken without affect.

I would give the game my whole attention, putting into words what was happening, experimentally naming possible affects: anger, desire to destroy, pain, fear, powerlessness. When I ascribed feelings of helplessness, pain, fear etc. to the monkey he generally commented with the words "serves him right", "he deserves more of this". But he usually fell back into his perseverative aggressive acts which were so violent that they tired him out physically. In my countertransference I felt more and more desperate and thought this would never end well, although inwardly I was in fact able to connect these feelings with his inner world. Nevertheless, in this period of treatment it was impossible to interpret any of these fended-off depressed feelings to him. If I offered interpretations he was immediately threatened by my words and ejected them into severe attacks on the monkey. It was also after about a year and half of our work together that he began to tie me up and even tentatively to cuff me. I took this as representing a development in the relationship and commented on the corresponding affects with something like "Mr Günter needs to be beaten because I'm so angry with him", "It has to hurt him because he keeps asking such stupid things about

school", "He has to be punished because he kept me waiting". He was now at least able to accept these comments, at times even answering with a brief nod. This was in contrast to the effects of my earlier attempts to interpret content. For instance, when he had made the shark and the monkey play wily, mean tricks on the small animals and then kill them in a cruel fashion, my comments had had no effect on his emotional state and had had no power to set any process of reflection in motion.

The beginnings of developments in symbolization

The first steps towards symbolic forms of communication developed very slowly, above all on the fringes of the treatment: at the end of the session he occasionally began to provoke me – and in doing so relate to me – by saying: "We'll see if I come at all tomorrow". He began – also after about a year and half – to say he was feeling so tired. He would lie down on my couch and fall asleep. What was remarkable was that he lay awake a long time before doing so. If I spoke to him from time to time he would just let out a sound or say two or three words and then fall silent. Finally, he would fall asleep sometime towards the end of the session.

The complex set of problems depicted here corresponds fairly exactly to my conception of ADHD as a disorder in thinking and affect processing in Bion's sense. Lukas was unable to process sense data and affects – that is to say, β-elements – adequately to form thoughts and so transform them into α-elements. Instead they shot directly into impulses and motor restlessness producing the symptoms of impulsivity and hyperactivity. What was even more fundamental was the resulting disorganization of thinking – in the sense of an inability to orientate his attention to inner representations and so achieve a coherence and flexibility in thinking. This led to severe failure in the school situation despite Lukas's clearly higher than average intelligence. Instead the picture was dominated by his distractability, the inability to relate two thoughts or two activities to one another, jumpiness in thinking and an insufficient development of mentalisation functions.

The work with Lukas often challenged my identity as psychoanalyst and in many sessions evoked countertransference feelings of hatred, anger, helplessness and desperation. After a year and half the situation escalated so badly that he was again threatened with being expelled from school. In the meantime another factor was that Lukas had no social contacts of any kind. Fantasies of grandeur got out of hand. He refused all forms of work and cooperation at school and was increasingly rebellious at home. Lukas, his parents and I agreed that things could not continue like this and we decided to admit him to our children's ward which allowed me to offer a continuation of the analysis at a frequency of four times a week.

After about two months of treatment in hospital, his parents and I broached the subject of the incident when Lukas was 9 months old and suffered an accident in which he was severely scalded with boiling water. This had once been mentioned in passing at the outset of the treatment. He had had to spend two weeks in hospital in extreme pain whenever dressings were changed – today this procedure would be carried out under

anaesthetic – and he must have screamed terribly. After this time in hospital he refused all physical closeness. He would turn away and could not be won over to any close tender emotional relationship to the despair of his mother. He rigorously kept his distance. In the session immediately following this conversation with the parents Lukas began to burn off the monkey's fur using the matches which were next to the Christmas arrangement of leaves and candles that was in my room.

For a number of sessions he concerned himself actively and in his imagination with singeing and burning the monkey's fur and was deeply interested in what happened. I took this opportunity to relate these activities and fantasies to his severe scalding as an infant and talked to him about the fear of dying, the despair and the pain and the fury as well as about his later rejection of human contact and of his own feelings. He responded to this, seeming really sad, and at certain points was able to understand when I interpreted his marked fantasies of violence as defence against depressed fears.

In the further course of the work Lukas carried his fantasies of violence into the daily life of the ward and into school. Even if only in part he managed at least to capture this in picture form. This is the picture of a devil which he painted around six weeks after the start of his inner tussle with his scalding (see Figure 1). He had to be constantly admonished: he was then for a short while able to distance himself from these fantasies of violence and seemed really shocked at himself. However they would soon return and he would come out with them in front of everyone in a way that was unbearable. So we decided to discuss it with him and agree that in future violent fantasies of this kind were to be confined to his sessions with me. In doing so we were pursuing two aims: one was that we hoped to create a break in his constant drifting off into fantasy worlds because that prevented him from taking any part in the daily life of school or hospital. The other was that I felt that these aggressively destructive parts of himself in fact belonged in the analytic session and should be given their own space there.

In these weeks, alongside playing with fire, Lukas had made several holes in the monkey's skin by repeatedly stabbing it with a pair of scissors. He had pulled out part of the stuffing, particularly the stuffing representing the brain, and usually stuffed it back in at the end of the session. One Wednesday session, he told me on our way over to the consulting room that the monkey was in for it because another patient had been annoying him. I asked what had happened and he told me that this patient had kept insulting him. It made him angry and he could not do anything about it. So the monkey would have to suffer. At this point I said that I thought he was leaving out one or possibly more steps in the story. He answered that he was leaving out the aggression. To which I said that that was the same as the anger. At this point it struck him that he had left out his fantasies of violence. I agreed and added that I thought he had still left out one step. So he asked me what it was and I offered the idea that he had left out the feeling of powerlessness and helplessness at the moment of being insulted. He instantly understood my brief suggestion and straightaway made a drawing of the sequence of events (see Figure 2).

Figure. 1. Lukas: Devil

At the top he sketched himself as a little stick man feeling helpless. The figure then grew angry, "said things" and finally reacted with destructiveness. I mentioned what I noticed: the middle figure, the one who was getting aggressive, was the only one who had a face. This, too, he grasped instantly. He remarked that the one who was getting violent had "lost it" (in German "lost himself"). For a moment he seemed thoughtful, almost depressed. Immediately after this moment he began to attack the monkey in the most violent way, throwing it against the wall and spearing it with the letter opener. He worked at it with all his strength, getting into a real sweat. While he was doing this he kept bringing up the thought that the monkey had to suffer. On my making a brief comment, he asked how it might be if one was able to resuscitate it. I said the monkey would have to suffer horribly and feel powerless and helpless. He took out the monkey's brain. Then he formulated the question again: was he dead and then he wouldn't suffer any more? Could one resuscitate the brain? And then he *would* suffer again? At this point I once again offered the interpretation

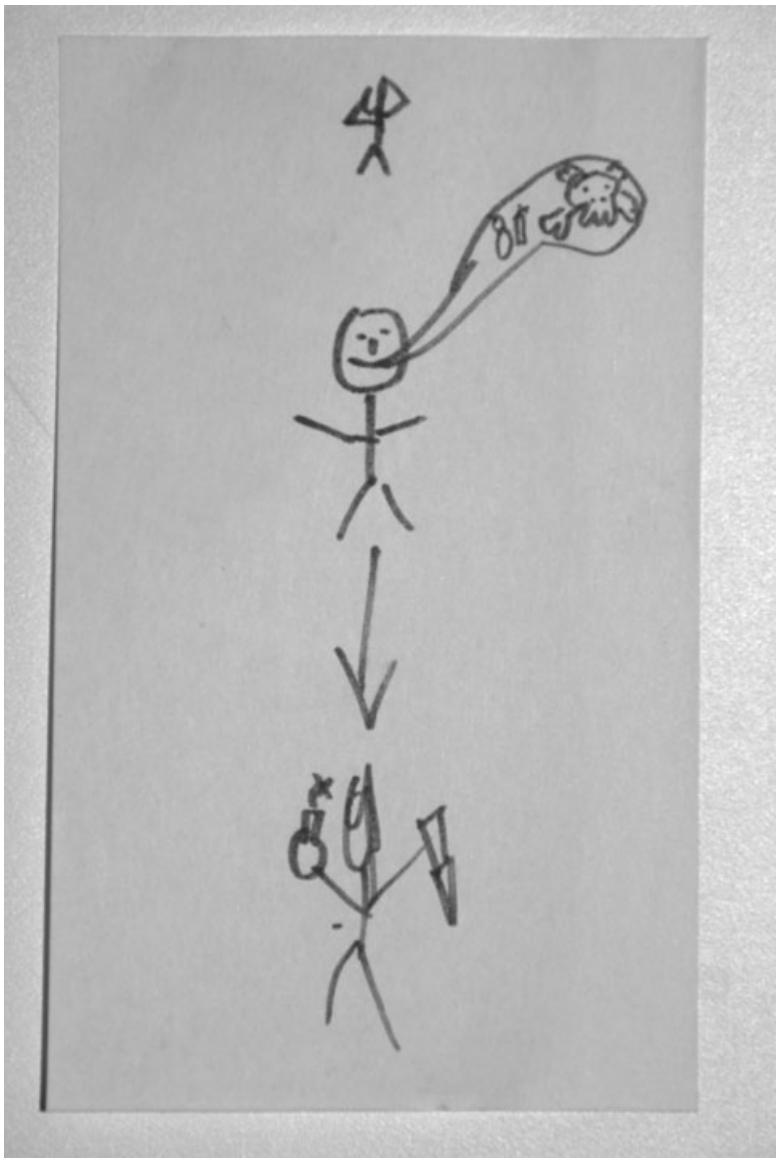

Figure. 2. Lukas: Sequence of events. Feeling helpless---growing angry–violent destructive fantasies

that his fantasies were an attempt to cut out feeling and thoughts in order not to have to suffer.

In the next session he said straightaway that the monkey would have to suffer. He started the session panting as if he was having a panic attack. I asked him about this and he didn't answer but calmed down relatively quickly. After that he laid into the monkey in his usual way: spearing it, throwing it against the wall or onto the floor. This escalated to the stage where he was showing no consideration for my furniture although we had agreed he would not damage it, and I had to admonish him a number of

times about this. Finally, he wanted to put the monkey on my torchiere floor lamp and grill it – which I did not allow. Instead I offered an interpretation that the monkey was to be grilled in the way he himself had been grilled. He answered that they could have given him an anaesthetic after all. The remainder of the session was about the fact that he was afraid of changing himself. He related this to being afraid of no longer being able to be violent and strong. Again I commented on the looming danger of feeling helpless and powerless which he found intolerable.

After this he began to tie up the monkey and stretch its extremities out with the string so that they were nearly torn off. Finally, he took up the scissors and set about cutting at the hip and began to cut off the leg. In my countertransference I was extremely tense during this session; his destructiveness weighed heavily on me and I communicated something of this feeling to him. One can see from this sequence the constant fluctuations in his emotional organization: at certain points he was able to bear depressed feelings and understand interpretations as communication between me and him on a symbolic level. If, however, my words induced feelings that were too powerful for him, maybe because I simply repeated an interpretation, wanting *him* to understand what made sense to *me*, he was taken over by paranoid anxieties and immediately reacted with stereotyped actions to ward them off.

In the next week he continued his violence to the monkey. I confronted him with the structure of his defence: that he was doing this kind of thing in order not to feel and not to think and I did not refrain from adding that this was isolating him, making him lonely and preventing him from achieving anything at school. He seemed to be thoughtful at certain moments and able to understand what I had said while I myself felt utterly drained, depressed and without perspective. In response to my interpretation of the vicious circle in which he was caught, he was at least able to say that in a certain card game he played he had a combination which meant the two sides got so destructive and worked up to such a point that there was no way out – they had to destroy each other.

A few sessions later he dressed the monkey in a wealth of bandages. I kept it on a shelf and from then on he turned to other things but every two weeks he went back to the monkey to check how it was. In the next three months there was sustained improvement. I shall give brief excerpts here from two sessions after his two and half years of analysis and nearly eight months in hospital in order to show how Lukas was at this point capable and willing to reflect on himself and his situation, at least for moments.

In one session we noted that things had improved from his point of view. He had hardly any fantasies of violence now and was managing significantly better in his social contacts. He entered seriously and thoughtfully into a conversation with me on his situation and on the question of how he was to solve his problems. He was thoughtful and sad. At this point I asked him whether he ever thought about his earlier therapist. He said no and fell silent. We had had this talk on a short walk which was something he had requested several times during the analysis when he was terrorized by paranoid feelings. In such moments interpretations had always made his situation worse, making his fears so unbearable that he broke off the session.

This was why I gave in to his demand and when we returned he hid himself. Then for the rest of the session he suggested we should go out onto the balcony. A mood of thoughtfulness settled on us which he interrupted by picking up a small stone and throwing it into the pond. He talked about how good it was to break something. He asked me if he could throw the next, larger stone down onto a car.

I made a relatively short, dry comment that he was probably trying to gain distance from a depressed mood with aggression and fantasies of violence. He reacted with a sudden question: "Where did that hole in the wall come from?" There was in fact a hole in the wall where a brick had fallen out. After that he asked if he might throw the large stone down into the water. To which I made a brief remark to the effect that I still saw this as having to do with breaking things. He threw the stone, trying seemingly for my sake to hit the edge of the pool but by mistake it hit the water which visibly gave him a bit of a shock. I just said: "Plop". He looked at me straightaway and seemed to have understood that I was referring to how aggression made affects and unease disappear.

The way I perceived this session was that, at first, he was dealing with his whole situation and with the long years in which his development had atrophied and he was dealing with it in a pensive, reflective way. When I got too close to him by reminding him of his earlier therapist – and therefore of all the misery of the years of his development – he withdrew and took flight in fantasies of violence. Then – and here there was a contrast to the past – when I referred to this he was able to perceive the hole in his mental apparatus triggered by noticing the hole in the wall. With a sense of shock he was able to perceive his deficits in thinking processes and in the processing of feelings.

He was able to accept a compromise – a compromise which I understand in the sense of a rudimentary process of digesting experience. My conviction is that at this stage of the treatment offering interpretations of content is less helpful and effective than orientating oneself to the patient's process of mental digestion and addressing the current status of its functioning. When this succeeded for a few moments he could allow himself to be lifted out of his mechanistic defence against states of feeling and their processing and to be brought into a two-way communication.

In the next session he unluckily had to wait for me for a few minutes. He hid. I commented that this was an inversion in which he was showing me what it was like to have to wait, a comment which had the effect of easing the situation. He wanted to play football, which I saw as a narcissistic flight, but at that moment I decided to accept the suggestion. He hit upon a game quite quickly: he was to be the goal-keeper and I was to shoot penalty kicks. He caught all my shots and was very skilled at it. There was a sequence at the end in which he warded off the ball in such a way that it flew over the high fence and almost hit a window on his ward. He immediately fantasized that this ball was going to smash through the window and land in the ward so we would not have to go and find it and clear up. I asked him what this meant for us. He evaded the question at first saying it was the end of our session. When I insisted it was a question of content he

asked me what that was and I said surely it was a matter of using violent force to smash through something and then – as he had fantasized – not having to go to the bother of clearing up afterwards.

He picked up on this instantly, saying I would certainly expect him to pay for the broken pane to which I replied: "In that case it would be as if I violently smashed through reality, then put the blame on you and didn't even have to clear up afterwards". He then said but the window pane would be strong enough not to break. My interpretation was: "So something would remain intact", to which he replied that he understood very well that reality could not be put out of operation by fantasies of violence. One *did* have to clear up. To stay with the image of the football game, this too, like many other moments in this final phase of the treatment, was a comment which I understood as a brief flare of remarkable thought processes after a long battle of defence against my intrusive shots (= interpretations).

A few weeks later Lukas was discharged from hospital treatment and went to a remedial therapeutic home with a school attached to it. He felt fairly comfortable there although he found it hard at first to get on with the group and with the school set-up. Gradually, and partly with accompanying medication which he had had most of the time of the analysis, he achieved a certain position in the group and then a reasonable status at school. Because of the distance we had to stop our analysis at this point and he could only see me once a month when he stayed at home over the weekend.

A parallel change was seen in the remarkable development in his processes of thinking and feeling which he reported to me in occasional meetings when he had weekend leave at home. He began to speak of the pain he felt in thinking how many more years of development he would need to become moderately normal and be accepted. He was now able to talk about his night-time fears of persecution and the feeling of not being really acknowledged or liked by anybody. He spoke of his despair but also said he hoped that he would gradually be able to cope with all this.

Conclusion

The therapeutic work in this treatment first of all had to be applied to fundamental deficits in thinking and in the perception and processing of affect which had led to a severe inability to relate to people and make contact with them. The destructive ways of behaving, which were at times extreme, were not accessible to any analysis or treatment of their content. They could only be registered in their quality of psychic pseudo-activity as a surrogate for genuinely 'live' conflicts and relationships. They were like industrially pre-fabricated thought and affect stereotypes and these are nowhere more easily available than in computer games. The most 'alive' element I could perceive in them – and that was only relatively speaking alive – was in Lukas's additional use of them as narcissistic armour. They lent themselves to being used for aggressive–destructive fantasies of grandeur so helping him to protect himself from experiencing deep disappointments, humiliations and extreme helplessness.

Therefore, I had to modify my analytic technique considerably. Over a long period of time I had to refrain from interpreting the sometimes more than obvious unconscious correlation between his aggressive destructive fixation and his identification with a terrorizing and persecuting bad object stemming from his early infantile traumatization and the following developmental impairment. My task as an analyst was to keep up thinking and affect processing activity in order to give him the opportunity to get curious about my mental activity. When I talked to him, my words served mainly to show him that there is still an α-function at work which might be helpful also for him to transform his unbearable affects and come to terms with them. For example, I often 'simply' insisted that there is still someone beneath him who is thinking about what he is doing in terms of affects and emotional relationship without claiming that I would know which specific affect his activity might represent and which unconscious source it might have. I showed in my paper how this step by step led to an identification with that kind of mental activity. After a long time of analysis he could gradually tolerate better – initially only for short moments – depressed feelings and was then able to take up my interpretations in their symbolic meaning.

This perspective on technique has some similarities with De Masi's 'considerations on the psychoanalytic theory of psychosis' when he concludes that psychoanalytic treatment of psychosis cannot work with the usual interpretive attitude derived from therapeutic experience with neurotic patients:

> Once the breakdown has occurred, analytic therapy of the psychotic state consists essentially in an attempt at non-omnipotent reconstruction, with the aim of restoring the functioning of the emotional unconscious, so as to give the patient back the use of his own awareness, thereby helping him to reconstitute his self-perception, personal identity and the functions that support it.
>
> (De Masi, 2000, p. 18)

although the mental processes of self-destruction are not as far-reaching in ADHD as they are in psychosis.

Using this analysis I have traced the possible function of dramatic stagings in the medium of play, of the patient's immersion in the virtual world and of the perseveratively repeated although theatrically staged action schemata which are virtually empty of content and appear mechanical: the function seems to be the warding off of affects and, indeed even more, the warding off of fear-inducing, painful and seemingly unbearable processes of thinking. In Lukas's biography this was anchored at a very early date which led to a deformation of his entire psychic development and a massive disorder in his ability to have relationships and to function in social and cognitive fields.

These forms of pronounced defence on the level of an attack on the functions in the mental apparatus of thinking and affect processing appear to me to be relatively typical of the symptomalogy of attention deficit hyperactivity disorder in its various forms. The aim of psychoanalytical work is to work step by step to pick up the 'staging', that is, the dramatization of the unconscious inner psychic conflicts and make use of its 'dramatology' to

use the term coined by Lothane (2009). This means as a first step perceiving it as the externalization of "intolerable inner dramas" (McDougall, 1985, p. 65) which "all await production on the analytic stage" (p. 17). Building on this, and even though the patient may outwardly seem to be avoiding any relationship, the analyst should understand his emotional storms and dramatizations as an offer of transference and take seriously the underlying, warded-off wish to provoke a response which in fact runs counter to the patient's conscious and cemented defence organization.

So the analyst should be ready to allow himself to be entangled at the start, or rather to entangle himself actively in what is being produced on the analytic stage. It is only when this succeeds that one can gradually work on the development of symbolic communication. In my paper I wished to show in what way that kind of development can be supported and to describe the necessary modifications in technique when analysing patients with ADHD. With the establishment of a symbolic communication the therapeutic technique gradually approaches the familiar process with interpretation of transference and restoration of genetic connections.

My vantage point with respect to therapeutic technique in the treatment of children with severe ADHD seems to be very much in line with Salomonsson's (2006, 2011) perspective. Starting from a description of different semiotic levels Salomonsson connected sudden deteriorations of the symbolization process in analysis to the presence or absence of an internal containing object in the patient. If the analyst can be experienced as a representative of a good internal object the patient can understand the interpretations, the words as carriers of symbolic messages (Salomonsson, 2006). If the internal object cannot contain the child's wishes and affects – Salomonsson speaks of faltering containment: "Such containment jeopardizes the child's thought processes in that the transformation (Bion, 1965) of beta-elements into alpha-elements is blocked" (Salomonsson, 2011, p. 91). On this level the child's internal "object seems inaccessible, dismissive, and contemptuous. When he tries to get in contact with it, it rejects and derides his efforts. Such experiences may unleash impulsivity, hyperactivity, and emotional outbreaks" (p. 89). In these situations words turn into missiles of the analyst's evil intent. They are experienced "as real things rather than messages about the child's feelings or thoughts" (p. 89). Salomonsson concludes that: "Verbal thinking is connected with the individual's 'awareness of psychic reality' (Bion, 1954, p. 114). Words make the child aware of his rage and the ensuing risk of loosing the good objects" (2011, p. 99). They make the child sad "because they remind him of his destructiveness. Sadness is then connected with an experience that the container does not understand, is not interested in him or is even contemptuous" (p. 99). Painful emotions and depression must be evacuated; they are ejected into the analyst via projective identification. Speaking about what happens on a symbolic level then would disrupt the connection between analyst and child and the patient's ability to reflect further (Salomonsson, 2006, pp. 1043–4).

Without wishing to cast doubts on a biological predisposition for ADHD, in at least a certain number of children, my own experience with children and adolescents who suffer from a marked attention deficit

hyperactivity disorder suggests we should definitely pursue the further development of our theoretical psychoanalytic concepts and psychoanalytic techniques of treatment of the disorder.

One reason that this seems necessary is that the psychoanalytic conceptualization of ADHD had so far been orientated to the classic repertoire of the understanding of early disorders on the one hand and oedipal neurotic developments on the other. This understanding has had consequences for the psychoanalytic treatment of ADHD which has been in danger of bypassing the core problems of the disorder. If to the two areas mentioned above one adds a third, namely that in ADHD there is a disorder in the functions for the processing of thought and affect – or, in other terminology, parts of α-function – this will mean that at least in severe cases treatment must concentrate on the functions of the mental apparatus. As I have already delineated, such a view of ADHD links up well with concepts of modern psychoanalysis. The originators of these concepts – above all, Bion's work deserves mention here – have given increasing attention to disorders in the processes of thinking, in the processing of affects and to the resulting disorders in object relationships, and have made these a central focus in their reflections on technique of treatment.

This way of seeing ADHD, as it is described in the case study, changes the psychoanalytic treatment of children and indeed of patients with ADHD in general. Content-based interpretations of conflicts have to be withheld for a long period or, in less severe cases, at least accompanied by work on the functioning of the mental apparatus, in particular on the ability to process affects through symbolization and the ability to enter into relations with objects. The difficulty of analytic work with these patients lies in trying to find a way with them to re-develop *L*, *H* and *K* (love, hate and knowledge, Bion): which means finding a way in which the patient can come to experience loving, hating and knowing in relation to objects and a way of making the fears that arise in the process become bearable.

Translations of summary

Aufmerksamkeits-Defizit-Hyperaktivitätsstörung (ADHS): Eine Affektverarbeitungs- und Denkstörung?. In der Literatur über Kinder- und Jugendlichenpsychoanalyse wird die Aufmerksamkeits-Defizit-Hyperaktivitätsstörung (ADHS) als komplexes Syndrom mit mannigfaltigen psychodynamischen Charakteristika beschrieben. Dabei können drei Kategorien unterschieden werden: 1. eine Störung der frühen Objektbeziehungen, die zur Entwicklung einer maniformen Abwehrorganisation führt, in der Ängste vor Objektverlust und depressive Affekte nicht symbolisierend durchgearbeitet, sondern körpernah organisiert werden; 2. eine Triangulierungsstörung, bei der die Besetzung der Position des Vaters instabil bleibt; Strukturen, die wenig Halt geben können, wechseln mit exzessiver Erregung, die Affektregulation ist beeinträchtigt; 3. aktueller emotionaler Stress oder eine Traumatisierung.
Ich schlage vor, die ADHS psychoanalytisch neu zu betrachten. Entlang der Phänomenologie der Störung sollte der konfliktdynamische Ansatz um eine Perspektive erweitert werden, in der sich eine defizitäre Alpha-Funktion als Grundlage der ADHS erweist. Diese Defizite verursachen Affektverarbeitungs- und Denkstörungen, die durch die Symptomatik (unvollständig) kompensiert werden. Auf einer weiteren Ebene wird durch die wechselseitige Verstärkung zwischen der defizitären Verarbeitung von Sinnesdaten und Affekten zu potentiellen Denkinhalten einerseits und sekundärer, weitgehend narzisstischer Abwehrprozesse andererseits ein Circulus vitiosus in Gang gesetzt. Diese Überlegungen besitzen erhebliche Relevanz sowohl für ein verbessertes Verständnis der ADHS als auch für die psychoanalytische Technik.

Trastorno por déficit de atención e hiperactividad (TDAH): Un trastorno en el procesamiento de los afectos y en el pensamiento.
En la literatura sobre el trastorno por déficit de atención e hiperactividad (TDAH) en niños y adolescentes, se lo describe como un síndrome complejo con rasgos psicodinámicos de amplio espectro. En términos generales, el trastorno se divide en tres categorías: 1. trastorno en las relaciones de objeto tempranas, que conduce al desarrollo de una organización defensiva multiforme en la cual la angustia de pérdida del objeto y los afectos depresivos no son elaborados mediante la simbolización, sino que son organizados de una manera cercana al cuerpo; 2. trastorno de triangulación, en el que la catexis de la posición paterna no es estable, las estructuras que suministran poco apoyo alternan con una excitación excesiva, y la regulación del afecto es limitada; y 3. tensión emocional actual o una experiencia traumática.
El autor sugiere echar una nueva mirada al TDAH desde la atalaya psicoanalítica. Con respecto a la fenomenología del trastorno, el enfoque de la dinámica del conflicto debe ser complementado por una perspectiva que considere que el déficit de la función-α es constitutiva del TDAH. Este déficit causa trastornos en el procesamiento de los afectos y en el pensamiento, que son compensados (aunque no plenamente) por la sintomatología. A un nivel secundario, se desarrolla un círculo vicioso mediante el reforzamiento mutuo de un procesamiento defectuoso de los datos sensoriales y los afectos en contenidos de pensamiento potenciales, por un lado, y, por el otro lado, procesos de defensa secundarios, en gran medida narcisistas. Estas consideraciones tienen gran relevancia para la mejor comprensión del TDAH y para la técnica psicoanalítica.

Le trouble du déficit de l'attention avec hyperactivité (ADHD): un trouble du traitement de l'affect et de la pensée.

1 Dans la littérature sur la psychanalyse de l'enfant et de l'adolescent, les troubles du déficit de l'attention avec hyperactivité (ADHD) sont décrits comme formant un syndrome complexe dont les caractéristiques psychodynamiques recouvrent un large éventail. En gros, ces troubles sont divisés en trois catégories : premièrement, il s'agit de troubles qui affectent les relations d'objet précoces et conduisent au développement d'une organisation défensive multiforme où faute d'élaboration symbolique l'angoisse de la perte d'objet et les affects dépressifs s'expriment dans le corps. Deuxièmement, des troubles de la triangulation où l'investissement de la fonction paternelle est instable; le manque de structure et de soutien alterne avec une excitation excessive et une régulation limitée des affects. Troisièmement, un stress émotionnel actuel ou une expérience traumatique.
2 L'auteur de cet article propose de jeter un regard nouveau sur ce syndrome à la lumière de la psychanalyse. En ce qui concerne la phénoménologie de ces troubles, l'approche psychodynamique lui semble devoir être complétée par des considérations qui placent les déficits de la fonction alpha au cœur de la constitution de l'ADHD. Ce sont ces déficits qui sont à l'origine des troubles de la pensée et du traitement des affects et la symptomatologie apparaît comme une tentative (imparfaite) d'y remédier. A un niveau secondaire, on assiste au développement d'un cercle vicieux par le biais du renforcement mutuel d'une transformation défectueuse des données sensorielles et des affects en des contenus de pensée, d'un côté, et de processus secondaires défensifs largement narcissiques, de l'autre. Toutes ces considérations se révèlent extrêmement pertinentes au regard de la compréhension des troubles du déficit de l'attention et de la technique psychanalytique.

Deficit di Attenzione/Iperattività (ADHD): Disturbo del processo delle emozioni e del pensiero?.
Nella letteratura sulla psicoanalisi infantile e adolescenziale, il Deficit di Attenzione/Iperattività (ADHD) viene descritto come una sindrome complessa che presenta vari aspetti psicodinamici. In linea generali questo disturbo si divide in tre categorie: 1. Difficoltà nelle relazioni oggettuali precoci che porta alla formazione di difese patologiche. Le angosce per la perdita dell'oggetto e le emozioni depressive non sono elaborate mediante il processo di simbolizzazione ma organizzate invece a livello somatico; 2. Difficoltà nel processo di triangolazione in cui la catessi della posizione paterna non risulta stabile; strutture di sostegno insufficienti si alternano a stimoli eccessivi e si riscontra una scarsa regolazione degli affetti; 3. Stress emotivo o trauma nel vissuto presente del soggetto.
L'Autore propone di riconsiderare l'ADHD da una prospettiva psicoanalitica. Per quanto concerne la fenomenologia del disturbo, una lettura in chiave di dinamiche conflittuali dovrebbe essere supplementata da una prospettiva riguardante eventuali mancanze della funzione Alfa, che potrebbero essere all'origine del disturbo. Tali mancanze sarebbero causa di disturbi nel processo del pensiero e delle emozioni che verrebbero compensati (sebbene soltanto parzialmente) dalla sintomatologia ADHD. Si assiste inoltre a un circolo vizioso in cui la difficoltà a trasformare le percezioni e gli affetti in contenuto mentale da un lato, e un'organizzazione delle difese a predominanza narcisistica dall'altro, si rinforzano a vicenda. Queste considerazioni hanno una grande rilevanza per la comprensione dell'ADHD e per la tecnica psicoanalitica.

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