

ADHD or Hyperarousal? Hyperactivity in Traumatized and Adopted Children

by Debbie Jeffries

When we first brought our adopted sons – then aged 4 and 6 – home, people were flabbergasted at their level of activity. They were constantly running, rolling, wrestling, flicking switches, going through cupboards, climbing shelves, talking non-stop, asking complete strangers intrusive questions, pulling things apart (and *never* putting them back together!), running across roads, ... in fact, I feel tired now just *thinking* about it!

Professionals told us that, because they were institutionalised children, it was just the excitement of entering a new world with lots of new things, and they'd soon settle down.

They didn't.

"People" would suggest to us (as "people" love to do) that they had ADHD. I knew otherwise. Aside from their frenetic physical activity, they didn't have the other signs of ADHD, and could focus well when they were motivated. The psychiatrist who later assessed my younger son for ADHD agreed.

Over the years, I was interested to see that a number of other adopted children displayed similar behaviour, and wondered. So I was fascinated when I heard Dr. Bruce Perry speak of the effects of trauma on the developing brain. The research on early trauma, neglect and attachment disorder explains a lot of the odd things that many adoptive parents see in our children.

Why? What does it have to do with adoption?

Many children adopted at an older age, like my sons, have experienced significant trauma, abuse and/or neglect. However, even for babies the mere act of separation from the birth parent is experienced, by some, as a significant trauma. Added to this, the multiple separations that many of our children endure (birth family, foster placements, orphanage) before they joined a permanent family can become a significant trauma, and they will have affected the child's ability to attach.

There is a lot of individual variation in children's' responses to these stressors, however - some children are more resilient, and are affected less than others.

I'll begin by describing the effects of trauma (or abuse) and neglect on children's brains.

(1) Trauma

There's plenty of hard scientific evidence now which shows just how trauma and neglect affect the child's developing brain.

Normal brain development:

At birth, the brain is quite undeveloped. It's responsible for regulating simple bodily functions, and little else. Over time, it develops in a sequential fashion, upward from the brainstem to the cerebral cortex, developing more complex structures which control higher order thinking and the ability to regulate emotions. This process of brain growth and development is, of course, guided by the child's experience. Perry says that "While experience may alter and change the functioning of an adult, experience literally provides the organizing framework for an infant and child".

This means that when a child experiences significant or repetitive trauma, there can be a lasting effect on the brain which actually impedes its development. Here's how.

The trauma or fear response:

Do you remember what you learned in high school science about the "Fight or Flight Response"? It's a primitive survival mechanism. When you experience a threat or stressor, your body prepares itself to either fight the threat, or to run away. It pours out stress hormones, mainly adrenaline and cortisol, which cause you to feel keyed up, your heart races, your muscles tense, your palms may sweat, you breathe quickly. You're hypervigilant, keying in

to nonverbal cues in the other person, such as eye contact, facial expression and body posture, or how close you are to the threat. *You can't think straight*. Your brain is so focussed on priming your body to fight or flee (engaging those very basic, primitive parts of the brain that the baby uses), that it doesn't engage any of your higher-order thinking.

In scientific terms, you're *hyperaroused*.

Lasting effects of trauma on the brain:

A child's brain is very malleable and, as mentioned above, is to a large degree shaped by its experiences. When a child experiences a trauma or fear which is extreme, or repeated, the hormones which are released in large amounts over time cause sensitisation of the brain areas involved in the stress response. This leads to a cascade of associated changes in brain-related functions and causes dysregulation of these functions. In other words, repeated "switching-on" of this adaptive fear response can result in the fear state persisting long after it's needed.

Specifically, a traumatized child may exhibit the following symptoms for years after the trauma has ceased – motor hyperactivity, anxiety, sleep problems, a racing heart, high blood pressure. He may be extremely impulsive, and may be hyper-reactive and hypersensitive – quick to arouse to anger and/or fear. These are symptoms which can look very much like ADHD.

"The vast majority of young children from backgrounds of abuse and neglect and other trauma who present to the mental health system with symptoms of aggression, inattentiveness and noncompliance are male. They typically are diagnosed with attention deficit hyperactivity disorder (ADHD)" (Perry, 1996).

All too sadly, this persisting fear response can stunt the development of the brain. Scientists describe how the brains of abused children are significantly smaller than those of non-abused, particularly the areas responsible for regulating emotion and for memory.

(2) Neglect

Scientists describe the effects of neglect on the brain as very similar. Neglect in itself can be quite traumatic, when you consider that being left on her own – physically or emotionally – causes a young child to become very fearful, even terrified. The fear created in her brain generates large amounts of stress hormones such as cortisol. When this happens repeatedly (as when a baby is left to cry for long periods, repeatedly), the brain, awash in cortisol, becomes sensitised, just as it does in more classic trauma.

(3) Attachment Disorder

Many adopted children have lived with a number of different caregivers – in institutions, foster families, even alone, on the streets – and have been unable to form an attachment to a significant caregiver.

It's an essential developmental task for a child to develop a secure attachment with a caregiver by the age of three. Without it, the consequences can be devastating. When the child experiences most of his needs being met by one person, he begins to learn trust and a sense of security. When that caregiver is a consistent, emotionally healthy person, there is a sense of "attunement" in their relationship. Schore (2001) describes this as when "the secure mother, at an intuitive, nonconscious level, is continuously regulating the baby's shifting arousal levels and therefore emotional states".

The normal cuddling, rocking, eye contact ("gazing") and play experiences with a consistent caregiver, cause the parts of the baby's brain which regulate emotion (probably in the limbic system) to switch on and grow. But when the child isn't able to develop a healthy attachment relationship, he misses the experiences which stimulate those centres. They don't develop properly, and thus he has difficulty regulating emotion and arousal, and responding effectively to stressors.

In short, he becomes hyperaroused in much the same way as the child who has been traumatised, and lacks the ability to calm himself down. His brain is immaturely developed and responds to stimulation in the same way as the tired toddler who plays an exciting game just before bedtime and can't settle down.

(4) ADHD

There *are* children who have Attention Deficit Hyperactivity Disorder (ADHD), and there are, no doubt, some

adopted children amongst those. I'm not suggesting that no adopted child has ADHD. However, I think that we should be careful not to confuse ADHD with the hyperarousal caused by early trauma, neglect or attachment disorder. ADHD is becoming a catch-all term for all sorts of other problems, and is, in the opinions of many other health professionals, over-diagnosed. If you think your child may have ADHD, make sure she's assessed by a good professional (a child psychologist or psychiatrist) who specialises in the area, and that the assessment is thorough (not just – "well, let's give her a try on Ritalin and see what happens).

In conclusion – some parenting strategies:

In the meantime, if you have a child who seems to fit the description of a traumatised or poorly attached child, even if only mildly so, try these strategies.

Think of him as an anxious and frightened baby who can't self-soothe. Provide a consistent, predictable pattern to the day. Help him to settle by limiting the time he spends at exciting, physical play and by getting him involved in some calming activities – activities such as reading, doing puzzles, playing with play dough. Time with a parent is usually very soothing, holding, touching or just by your side helping, chatting, or even sitting. Keep him quietly with you for as long as you can manage. If you can only manage a couple of minutes of quiet to start with, that's OK – you can work on lengthening the periods. I say, quite directly, to my son "You need some quiet time now, your brain's having difficulty calming down".

If he flies off the handle over something trivial, don't argue with him. You can't reason with someone who's frightened – do that later, when he's settled. Be sympathetic but firm, and stay calm. A display of anger and strong emotion will escalate the situation.

Learn to read the signs that he's getting out of control, and stop him before he escalates. His environment needs, ideally, to be low on stress and stimulation and high on parental contact and calm.

Further Reading:

www.childtrauma.org - Website of the Child Trauma Academy

Keck, G. & Kupecky (2002), *Parenting the Hurt Child*. Pinon Press.

www.trauma-pages.com - Trauma Information pages – many great articles.

Schore, A.N. (2003), *Affect Dysregulation and Disorders of the Self* W.W. Norton & Company.