

Emotional Regulation

by William W. Dodson, MD

THE DIAGNOSTIC CRITERIA FOR ADHD have never mentioned “problems with emotions and mood regulation” and yet anyone who has ADHD will tell you about their:

- flash temper
- low frustration tolerance
- being easily overwhelmed by emotions
- inability to keep from feeling the pain of others and getting flooded. At the same time they can seem cold, insensitive, and unaware of the feelings of others.
- exquisite sensitivity to rejection and criticism,
- hopelessness and demoralization

More than thirty percent of adolescents and adults with ADHD list their emotional instability as the most impairing aspect of their ADHD. Yet the primary reason emotions have never been a part of the diagnostic criteria is because they do not lend themselves well to research methods requiring the thing being studied to be always there and visible so it can be counted. The diagnostic criteria and most research concern behaviors which can be seen and counted. Researchers behave as if the emotional component were not even there.

There are three major types of mood problems in ADHD. Two are commonly found associated with a number of other conditions, but one, rejection sensitivity, seems to be associated exclusively with ADHD.

Over-reaction

People with ADHD lead intense, passionate lives. If they are not interested or do not care about something, it is not on their radar screen. Consequently, they care deeply about what is left. It is rarely evident to others why they get so keyed up over things that objectively seem rather minor.



Rejection Sensitivity



SHUTTERSTOCK/ AARON AMAT

The ADHD brain has a hard time regulating emotion because it struggles to distinguish between dangerous threats and minor problems. People with an ADHD can be “dangerously daring” when unaware of high-risk behaviors and then panic over relatively small challenges (“have to be talked in off the ledge”). The hyperarousal of ADHD means that most people with ADHD never experience peace. Their minds are always going 100 MPH until they are totally exhausted.

Shame and guilt

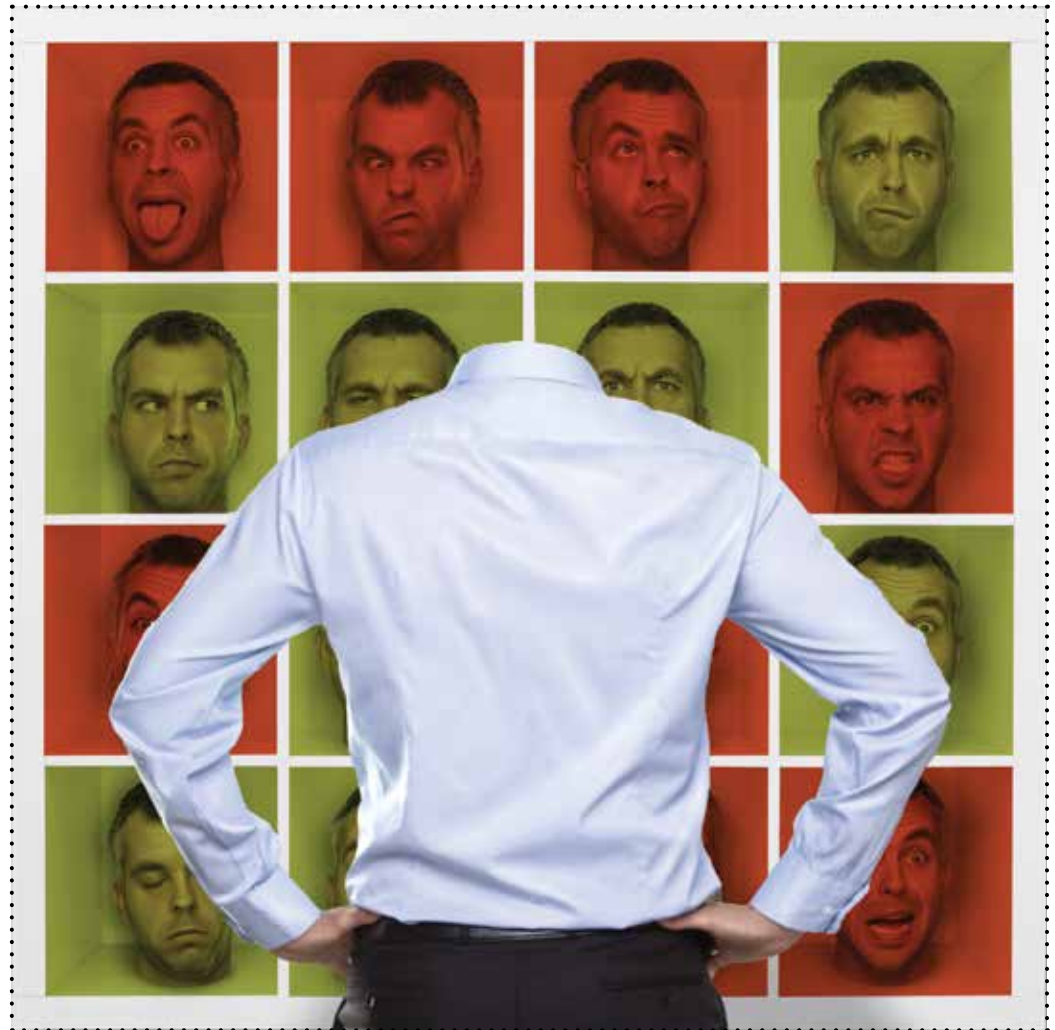
Children with ADHD hear 20,000 additional critical or corrective messages before their twelfth birthday when compared with neurotypical children. This cannot help but have a tremendous impact on the emotions and sense of self of a developing child. People with ADHD are “the last picked and first picked on.” Most grow up with the feeling that they are less than, uncool, unwanted, defective, incompetent, and “damaged goods.”

The resulting shame and guilt often negate positive feedback and the formation of a positive self-image. Freud called shame the “master emotion,” because it dominates all other emotions and determines when and how the other emotions can be expressed or dealt with. By its very nature shame and guilt are hidden by the person and not confessed to even their closest friends. The resulting low sense of self-esteem is a constant torment and sucks the pleasure out of everything a person does.

Rejection sensitive dysphoria

Rejection sensitive dysphoria (RSD) appears to be the one emotional condition found only with ADHD. Early research on ADHD intentionally ignored rejection sensitiv-

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ity because it was not always there, it was often hidden by the person with ADHD, and because there was no way to measure rejection.

RSD is an extreme emotional sensitivity and emotional pain triggered by the perception or imagination by the person with ADHD that they have:

- been rejected
- been teased
- been criticized
- disappointed important people in their lives
- withdrawn their own approval of themselves when they failed to attain their own standards or goals

The pain is extreme. “Dysphoria” is literally Greek for “unbearable.” The pain is so primitive and overwhelming that people struggle to find any words to describe it. They can talk about its intensity (“awful, terrible, catastrophic”) and cannot find words to convey the quality of the emotional pain.

If this emotional response is internalized, it looks like an instantaneous but triggered major depression. Most

psychiatrists are trained to see depression and totally miss the ADHD. It is often mistaken for “rapid cycling” bipolar or borderline personality disorder due to the interpersonal nature of the catastrophic emotional response.

If the response is externalized, it manifests as a rage at the person or situation that wounded the person so severely. (Fifty percent of people who are court mandated for anger management treatment have previously unrecognized ADHD.)

This RSD phenomenon is often misdiagnosed as social phobia. Social phobia is an intense *anticipatory* fear prior to a public event that the person is going to do or say something embarrassing in public or be scrutinized harshly. Once the person is in the anxiety-provoking situation, the anxiety diminishes or even goes away. RSD is a *triggered*, wordless emotional *pain* that occurs *after* a real or perceived loss of approval, love, or respect.

Impact and impairments of RSD

About a third of adolescents and adults list RSD as the

most impairing aspect of their ADHD. They have found ways around their academic or work performance issues, but they are still highly vulnerable at any moment to misinterpreting some minor slight or tone of voice as a devastating rebuke.

To some degree or another, most people with RSD become people pleasers. They quickly scan every person they meet and have a remarkable ability to figure out exactly what that person would admire or praise. They then present that very pleasing false self to the world. They are so intent on avoiding the possibility of displeasure from others and keeping everyone happy that they often lose track of their own goals and desires. By the time they get to their forties, they have built up a huge well of resentment about having given up their own lives to attend to the perceived needs of everyone else and getting nothing in return.

The other most common way of protecting oneself from the extreme pain of RSD is to give up trying anything new unless one is assured of quick and complete success. The notion of trying and failing or being turned down is just too painful to risk. They don't go on dates. They don't apply for jobs. They don't speak in meetings or make their ideas and needs known to anyone.

There are some positive aspects of RSD. It commonly creates a desperate drive to achieve and excel. It creates a drive to be perfect or at least "above reproach." But at what cost? Perfectionism is an unattainable goal. People with RSD become false shells or performers, but they must be constantly striving and achieving because they know that "today's audience does not applaud yesterday's performance." They never experience "peace."

Treatment of RSD


Since RSD is genetic and neurological, psychotherapies have been found to have little benefit. While early childhood trauma can make anything worse, it does not cause RSD. Often just knowing what is going on, that they are not defective or "head cases," is a relief. Others experience the same thing. It is not their fault, nor are they damaged.

The simplest treatment is with one of the alpha-agonist medications, guanfacine or clonidine. Both medications are FDA-approved for the treatment of ADHD, especially the hyperactivity that defined the syndrome at one time. Unfortunately, only one out of three people get a robust benefit; the rest just get mild sedation. But for the lucky ones, the change is nothing short of life changing and freeing. Most report that the benefits to their quality of life are much greater with an alpha-agonist than they experienced with stimulant medication. Side effects are dry mouth, mild sedation, and more frequent dizziness if the person stands up too quickly.

There is an off-label (that is, not FDA-approved for ADHD) treatment that was commonly used back in the early days of ADHD that can be dramatically effective for both the attention/impulsivity component of ADHD and for the RSD. These medications are the monoamine oxidase inhibitors (MAOIs) and, in particular, tranylcypromine.

There are several advantages to tranylcypromine. Researcher Paul Wender did a study back in the 1960s that compared tranylcypromine (and other MAOIs) head to head with methylphenidate and found that they were equally effective for the core symptoms of ADHD. Tranylcypromine was low in side effects, had true once-a-day dosing, and was not a controlled substance (no abuse potential). It had a high quality, relatively inexpensive generic, and was FDA-approved for both depression and anxiety disorders. Wender stated that the MAOIs were his treatment of choice for adults with ADHD.

But that kind of silver lining has to have a dark cloud. People must follow a diet that avoids foods that are aged instead of cooked (for example, aged cheese, soy sauce, high-end aged sausages, etc.). An amino acid called tyramine found in aged or spoiled foods is not destroyed when it enters the body and quickly gets converted to adrenaline, which then causes blood pressure to rise to very high levels. Back before these interactions were understood, people died of strokes due to suddenly spikes of blood pressure. Most of the MAOI diets on the internet and in textbooks were written forty years ago when the "cheese reaction" was poorly understood and foods with any tyramine were forbidden. We now know that it takes much more tyramine to produce a reaction than previously thought and people who eat a balanced diet in moderation usually do not have to make any changes. Modern diets based on forty years of additional research are available at www.psychotropical.com.

MAOIs cannot be taken with a list of medications that include the first-line ADHD stimulant medications, almost all of the antidepressant medications, OTC cold, sinus and hay fever medications, OTC cough remedies, and some forms of anesthesia. (A list of medications is available at the same website.) Consequently, a trial on tranylcypromine usually requires a clinician with experience with MAOIs and tranylcypromine. 

William W. Dodson, MD, is a board-certified adult psychiatrist who has specialized in ADHD for the last twenty-three years. He is currently in private practice in Denver, Colorado. He has written on how the basic research on ADHD can be applied to everyday clinical practice. Dodson is a Life Fellow of the American Psychiatric Association and was the 2006 recipient of the Maxwell J. Schleifer Distinguished National Service Award for his work with people with disabilities. His forthcoming book is titled, *What You Wish Your Doctor Knew About ADHD*.