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Letter

ADHD, autism or complex trauma? The complicated nature of the question

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Increasingly, individuals with and without a history of childhood trauma are wondering whether they have attention-deficit hyperactivity disorder (ADHD) and/or high functioning autism.[1] This rise in interest and, at times, conviction, is challenging clinicians and resources. Social media, increased knowledge and destigmatisation, the cognitive demands of modern life, and the ability of psychostimulants to improve motivation and focus (or at least diminish aversion to prolonged focused or mundane tasks) are all likely to contribute to a perfect storm overwhelming public diagnostic and treatment systems.

My work is in the field of adults seeking treatment for childhood trauma. In this field in particular, the overlap is complicated. Executive function is acquired developmentally, and adverse childhood experiences are associated with functional and structural brain differences in the regions that are important to executive function,[2] with lasting executive impairment through to adulthood.[3] What is often overlooked in this association is that limitations in executive functioning and socioemotional capacity predispose individuals to risk of childhood abuse,[4] inform their ability to cope with the impact of trauma[5] and are risks for subsequent development of post-traumatic stress disorder (PTSD).[6,7] My hypothesis is that that those who remain most affected by childhood trauma in adulthood and seek treatment for it represent a population more likely to have innate neurodiversity. The high heritability of ADHD and autism means that parents who have executive functioning and social/emotional challenges are more likely to have children with the same. These parents as a group, particularly if undiagnosed and untreated, are more likely to show emotional dysregulation and be at risk for abusive behaviour, particularly to a child who also struggles with impulsivity and disruptive behaviour.[8]

On the other hand, I also have seen that individuals with childhood trauma are more likely to misperceive themselves as having neurodiversity because of social deficits, sense of otherness, and repetitive and dissociative coping strategies. Lack of appropriate parental modelling, shame, anxiety and generalised mistrust can hold individuals back from engaging and acquiring developmentally appropriate social skills. Emotional and interpersonal dysregulation further impair social capacity. Chronic nervous system activation and hypervigilance can lead to sensory sensitivities, social fatigue, and compulsive and dissociative forms of coping, including perfectionism, rigid adherence to rules and control of personal space, compulsive self-soothing behaviours, eating disorders, retreat into solitary interests, emotional numbing and dissociative loss of time. Moreover, the anxiety, sleep disruption, depression and chronic health conditions that often accompany adult survivors each individually contribute risk to executive dysfunction, although the onset of such may not occur until adolescence or adulthood.

There is currently a lack of evidence on how to treat this later-onset executive dysfunction. Although patients are desperate for assessment for ADHD and/or autism, treatment with a psychostimulant for non-ADHD executive dysfunction lacks robust evidence, and potential side-effects of psychostimulants, which include heightened arousal, depression, insomnia, irritability and anxiety,[9] could rather worsen core PTSD symptoms and comorbidities. Failure to address executive dysfunction means that treating PTSD symptoms may not translate into improved functioning in life, i.e. ability to work, maintain friendships and gain financial stability. Without stability and forward momentum in these areas, it is very difficult to move beyond the memory and impact of childhood trauma.

So what is the way forward? For now, best practice in adult diagnoses is to ensure that symptoms of ADHD and/or autism were present in childhood. For ADHD, this requires corroboration from ideally a parent, which is not always possible when abusers were parents and adults have estranged themselves from their family of origin. Review of old report cards is ideal if available. Self-report is challenged by overshadowing of current distress, impairment and at times desperation when other treatments and years of therapy have not led to adequate functioning. If there is a history of treatment-resistant depression (not just affect dysregulation), then treatment with bupropion or augmentation with a stimulant may be beneficial and evidence-based,[9] and noradrenergic agents such as serotonin–noradrenaline reuptake inhibitors may also support some improved focus associated with generalised anxiety and depression. More research is needed to determine whether executive dysfunction in adults with complex PTSD who did not present with ADHD symptoms as children respond to and tolerate ADHD medications.

What also remains to be determined is whether psychotherapeutic approaches for treating complex PTSD improve executive function and functional outcomes, and, if not, how therapy needs to be modified to address these challenges. In my clinical experience, those most affected by executive dysfunction require therapy to be more directive, specific and accountable; that is, processing of past trauma and relational approaches are not sufficient. What often does not seem like trauma therapy at all can lead to great strides forward if it allows individuals to obtain a greater sense of structure and mastery in day-to-day life tasks.

Perhaps what is compelling more people than ever to seek a diagnosis of ADHD and/or autism is a growing dissatisfaction with the societal belief that individual choice drives success through wilful motivation and hard work. People are born into the world with different levels of opportunity and resources, including capacity for focus, planning, motivation, emotional regulation and impulse control. Life circumstances beyond their control, including trauma, further affect the development of these capacities. A diagnosis of ADHD or autism in adulthood often leads to incredible relief and grief in processing all the moments of being blamed and shamed for what was assumed to be a lack of effort, laziness and/or defiance. But

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ADHD and autism are not pinpoint diagnoses; they are on a spectrum, with severe symptoms at one end, and a range of capability and impairment. A trauma-informed perspective calls for a person-centred approach that starts with an individual's experience of suffering and challenges and seeks to alleviate shame to enable people to achieve their fullest potential.

Although the conundrum of diagnosing ADHD and autism in adults with complex childhood trauma is far from resolved, this population suffers from increased rates of executive dysfunction and social challenges. More research is needed to understand how best to identify and support these challenges to promote both symptom and functional recovery in life.

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Declaration of interest

None.

References

1 Morris J. *The Rapidly Growing Waiting Lists for Autism and ADHD Assessments*. QualityWatch: Nuffield Trust and Health Foundation, 2024.

2 Hinojosa CA, George GC, Ben-Zion Z. Neuroimaging of posttraumatic stress disorder in adults and youth: progress over the last decade on three leading questions of the field. *Mol Psychiatry* 2024; **29**: 3223.

3 Op den Kelder R, Van den Akker AL, Geurts HM, Lindauer RJL, Overbeek G. Executive functions in trauma-exposed youth: a meta-analysis. *Eur J Psychotraumatol* 2018; **9**: 1450595.

4 Stern A, Agnew-Blais J, Danese A, Fisher HL, Jaffee SR, Matthews T, et al. Associations between abuse and neglect and ADHD from childhood to young adulthood: a prospective nationally representative twin study. *Child Abuse Negl* 2018; **81**: 274.

5 Yule K, Houston J, Grych J. Resilience in children exposed to violence: a meta-analysis of protective factors across ecological context. *Clin Child Family Psychol Rev* 2019; **22**: 406.

6 Bardeen JR, Gorday JY, Weathers FW. Executive functioning deficits exacerbate posttraumatic stress symptoms: a longitudinal mediation model. *J Anxiety Disord* 2022; **87**: 102556.

7 Wendt FR, Garcia-Argibay M, Cabrera-Mendoza B, Valdimarsdóttir UA, Gelernter J, MB Stein, et al. The relationship of attention-deficit/hyperactivity disorder with post-traumatic stress disorder: a two-sample Mendelian randomization and population-based sibling comparison study. *Biol Psychiatry* 2023; **93**: 362.

8 Crouch JL, Davila AL, Holzman JB, Hiraoka R, Rutledge E, Bridgett DJ, et al. Perceived executive functioning in parents at risk for child physical abuse. *J Interpers Violence* 2021; **36**: 8874.

9 Pucci SL. Use of psychostimulants in the management of treatment-resistant major depressive disorder. *Ment Health Clin* 2025; **15**: 197–200.

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