Syrjänen, M., Hautamäki, A., Pleshkova, N., & Maliniemi, S. (2019). Self-protective strategies of parents with ADHD and their children as mediated by sensitivity – a multiple-case study. *Journal of Children`s Services, 14(4)*, 278-291. DOI: 10.1108/JCS-09-2018-0018

Authors

Milla Syrjänen,[1] Airi Hautamäki,[2] Natalia Pleshkova,[3] and Sinikka Maliniemi[4]

[1]
Faculty of Educational Sciences, University of Helsinki, Finland.

[2] Swedish School of Social Science, University of Helsinki, Finland

[3] Division of Child and Parent Mental Health and Early Intervention, St.Petersburg State University, Russian Federation

[4] Private practice in psychotherapy, Helsinki, Finland

Abstract

Purpose – The purpose of this paper is to explore the parental sensitivity and self-protective strategies of parents with attention deficit hyperactivity disorder (ADHD) and those of their children.

Design/methodology/approach – Six parents with ADHD and their under 3-years-old children participated. One parent took part with her both children. The data included seven parent-child dyads. The parents were interviewed with the modified Adult Attachment Interview. Parental sensitivity was assessed using the CARE-Index. The self-protective strategies of the children were assessed with the Strange Situation Procedure or the Preschool Assessment of Attachment.

Findings – The study showed a variety of the self-protective strategies of parents with ADHD as well as those of their children. Three subgroups were formed on the basis of risk as indicated by Crittenden's gradient of transformation of information. Parents displayed complex self-protective strategies as well as unresolved traumas, which impaired their sensitivity and ability to engage in mutual regulation of arousal and emotion. The parents' needs of self-protection compromised their ability to protect and comfort their child that is their sensitivity. The children's protective strategies matched those of their parents in regard to complexity as mediated by parental sensitivity.

Originality/value – This multiple-case study demonstrates new ideas to be tested with quantitative methods in larger samples. There are no previous studies which have examined both the attachment strategies and sensitivity of parents with ADHD connecting these with the evolving attachment strategies of their children.

Keywords

ADHD, Attachment, Self-protective strategy, Sensitivity, DMM AAI, CARE-Index, SSP, PAA

Paper type

Research paper

Introduction

Attention deficit hyperactivity disorder (ADHD) is a common psychiatric condition and both genetic and environmental risk factors contribute to this familial and multifactorial disorder (Thapar and Cooper, 2016). In attachment theory, ADHD has been conceptualized as a disorder of self-regulation rooted in troubled early caregiver-child interactions (Clarke et al., 2002), and connected with insecure and disorganized attachment (see Storebø et al., 2016). These studies have been made in terms of the ABC+D model in which the category D/disorganized focuses on particular infant behaviors as indices of breakdown of the attachment system in moments of heightened stress (Main and Solomon, 1990). In the present study, the Dynamic Maturational Model of Attachment and Adaptation, DMM (Crittenden, 2016a), another clinical expansion of Mary Ainsworth's original work is used, because it may be better attuned to the issues of parental adequacy (Spieker and Crittenden, 2018). ADHD appears to be associated with troubled parenting and insufficient protection and comfort contributing to the "bonding break" connected to spiraling, deteriorating cycles of coercive interaction, as analyzed by Ladnier and Massanari (2000) and with "the demand-dissatisfaction cycle" undermining the creation of "a routine of management," as described by Stiefel (1997) (for a review of parenting and ADHD, see Hechtman, 1996 and Deault, 2010). Some more recent studies have shown difficulties in parenting, if the parent has ADHD (Johnston et al., 2012) or if both the parent and the child have ADHD (Chronis-Tuscano et al., 2008; Ellis and Nigg, 2009; Murray and Johnston, 2006). Semple et al. (2010) studied early parental sensitivity of adults with ADHD. They found that maternal ADHD symptoms were associated with troubled maternal caregiving behaviors during infancy. However, to our knowledge, there are no previous studies which have examined both the attachment strategies and sensitivity of parents with ADHD connecting these with the evolving attachment strategies of their children.

Parenting includes the protection and comfort of the immature child (Crittenden, 2016a). Protection refers to keeping the child safe physically and emotionally so that the child can mature in accordance with his inherited potential and is given the possibility to use and develop his physical and psychological resources. Comfort means that the child both can use his parents as a secure base from which he safely can explore the world as well as secure haven to return to, when he needs comfort. Exploration includes that the child is assisted in learning to use his own mind to create self-protective meaning from his experience – a condition for that he can achieve genuine independence by adulthood (Landini et al., 2016). Attachment theory describes and analyzes individual differences in these parental functions (Bowlby, 1980; Crittenden, 2016a) and stresses that parenting is based on the parent's dispositional representations of attachment (Crittenden, 2016a) as assessed by the Adult Attachment Interview, AAI (George et al., 1985). Attachment is defined in terms of three aspects (Crittenden, 2016a, p. 10): "a unique, enduring, and affectively charged relationship with one's mother or partner, a strategy for protecting oneself and one's progeny, particularly, under dangerous conditions, and the pattern of information processing underlying the strategy." In particular, the DMM AAI can identify parents whose pattern of information processing may put their children at risk through inadequate protection from danger, insufficient comfort and lack of clarity of communication (Spieker and Crittenden, 2018, p. 11): "One clinical advantage of the DMM is that its dimensional array of attachment strategies based on information processing sorts children and families reasonably accurately by risk status."

Crittenden et al. (2014) stress the functional significance of ADHD symptoms of a child in family interaction (see also Crittenden and Kulbotten, 2007; Dallos and Smart, 2011). They state that the ADHD symptoms can be conceptualized as an adaptation to a triangulated family system and connected to a variety of self-protective strategies and the modifier "disorientation." Disorientation, DO, is a high arousal state that functions in a non-strategic way because of a source memory problem. If the source memory of information is omitted from the dispositional representations every bit of information becomes self-relevant (Crittenden and Landini, 2011, pp. 261-262). According to Crittenden et al. (2014), the diffuse, high arousal connected to ADHD symptoms, being distractible and distracting, response-ready, is characterized by the ability to scan widely with a short attention span (Jensen et al., 1997) for hidden, unavoidable and inescapable dangers, at the same time not knowing what to attend to. This state may have early roots in the infant's attachment relationships, in particular, the lack of clarity of communication. ADHD is connected to problems in discerning what is relevant to attend to, in particular, self-relevant danger. The child may become disoriented, when parents are responding to problems in their marital relationship, or to their own traumas, which are only partially related to the child. Instead of offering adequate protection and comfort and instead of helping the child to make meaning of his experiences, the distressed parents may feel urged to protect themselves (Crittenden et al., 2014).

The present study was conducted using The Dynamic Maturational Model of attachment and adaptation (DMM) that focuses on adaptation to danger. The array of DMM self-protective strategies are grouped as Types A, B and C, originally identified by Ainsworth (Ainsworth et al., 1978), with many sub-strategies, as described by the DMM (Crittenden, 2016a; see Figure 1). Following Landini et al. (2016), the classic Ainsworth strategies in the normative range (A1-2, C1-2) were considered low risk. The higher A+ and C+ strategies elaborated by the DMM ranged from moderate risk (A3-6, C3-6, AC) to high risk (A7-8, C7-8, AC). The risk was defined in terms of the gradient of transformation of attachment-relevant information (Crittenden, 2016a). In regard to parenting, strategies numbered "3-4" indicate that parents at times may transform information in a way that confuses their own needs with those of their child, "5-6" indicates transformations that parents at times act self-protectively rather than child-protectively and "7-8" indicate distortions of information ranging to delusionally construing the child as a threat to the parent (Landini et al., 2016; see also Crittenden, 2016a, for the gradient of transformation of information). Syrjänen et al. (2019) conclude on the basis of their multiple-case study of parents with the ADHD diagnosis that though the complexity of the parents' self-protective strategies varied some parents' need for self-protection compromised their ability to protect their child and decreased their sensitivity.

The aim of this multiple-case study was to describe the self-protective strategies of parents with ADHD as well as those of their children as mediated by parental sensitivity. The multiple-case study design was fit for the exploratory purpose of this study.

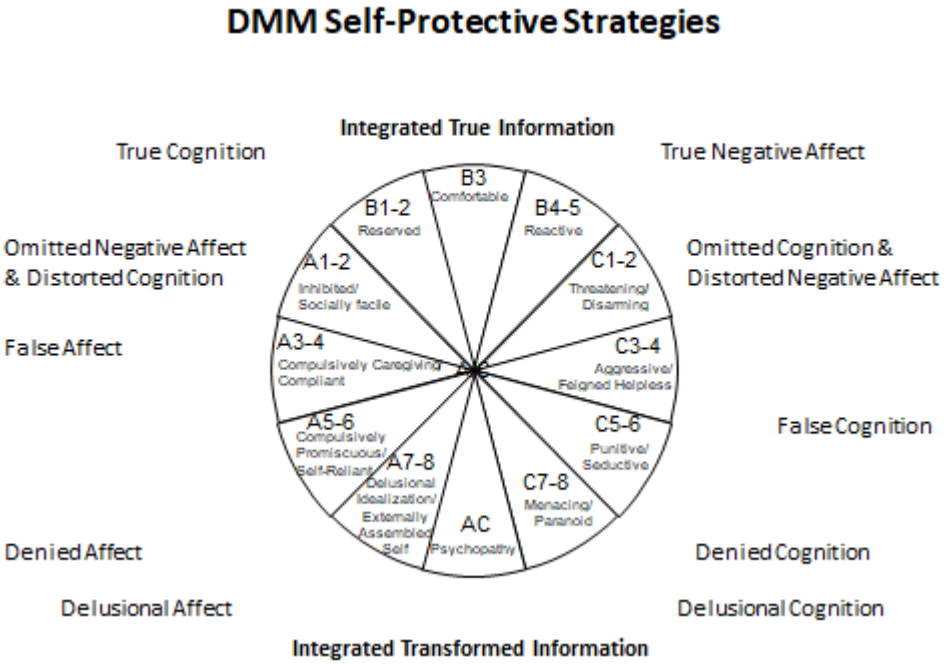

Figure 1. DMM Self-Protective Strategies (© Patricia M. Crittenden, used with permission)

Methods

Participants

Six parents (five mothers, one father, mean age = 32 years; range = 23.0–39.3) and their under 3-years-old children were recruited from a University Central Hospital, Department of Psychiatry, Clinic for Neuropsychiatry. All the clients of this clinic, who fulfilled the inclusion and exclusion criteria, were invited to participate in the study between January 2013 and November 2015. However, the respondents were hard to find, because individuals with ADHD often have other psychiatric diagnoses. In this study, the parents are identified as P1–P6 and the children with pseudonyms. P3 participated with her both children. Thus, the data included seven parent-child dyads. The study was approved by the Medical Ethical Committee of the University Hospital in question. The respondents gave written informed consent.

Exact selection criteria were used to form a uniform sample. For the inclusion in the study, the parents: age range was 22–45 years; had received the ADHD diagnosis from a University Central Hospital, Department of Psychiatry, Clinic for Neuropsychiatry; lived on their own; spoke Finnish as the first language; had received at least six Apgar points at the time of birth; had a 0–36 months old child. For the exclusion, parents: had a comorbid DSM-IV diagnosis and ongoing regular use of psychotropic medicines, except for the ADHD-medication; had participated in any form of psychotherapy.

The ADHD (combined subtype) diagnosis had been assigned to each parent by psychiatrists at a University Central Hospital after the diagnostic assessment based on multiple sources of information, e.g., The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) (First et al., 1996), The Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II) (First et al., 1997) and Conners' Adult ADHD Diagnostic

Interview for DSM-IV (CAADID) (Epstein et al., 2001). Also relatives were interviewed and clinical records dating back to the birth were collected from public and private health services. In combined subtype both inattention and hyperactivity-impulsivity symptoms have to be met (see American Psychiatric Association, 2000). Though the parents had received the ADHD diagnosis as adults, it was verified during the diagnostic process that they had shown ADHD symptoms already as children. With the exception of one parent, all had the ongoing ADHD-medication at the time of the study and had received outpatient therapeutic counseling. They had completed secondary school. Three had finished some kind of education after that. All parents lived with their children. With the exception of one mother, all parents cohabited or were married with their partners at the time of the study.

Assessments

The parents were interviewed using the DMM AAI, which is a semi-structured, standardized and validated interview, elaborated from the Adult Attachment Interview (George et al., 1985). The transcripts were coded by two coders, of which one had research-level reliability.

The sensitivity of parents was assessed using the CARE-Index (Crittenden, 2005, 2010; see also Künster et al., 2010), which is an observational assessment procedure for categorizing parental and child patterns of interaction based on 3–5 min of videotaped semi-structured play interactions. The videotapes were coded by two coders. One of the coders had research-level reliability in the Infant CARE-Index and the Toddler CARE-Index. P.M. Crittenden classified four interactions. Her evaluations matched that of the coders.

The attachment strategies of children between 11 and 15 months were assessed using the strange situation procedure (SSP), which is a structured laboratory separation–reunion procedure consisting of eight 3min episodes designed to be increasingly stressful for 11–15-month-old infants (Crittenden, 2016b). The SSP was coded by two coders, who had research-level reliability.

The attachment strategies of children over 15 months were assessed using the Preschool Assessment of Attachment (PAA), which is a validated method of coding strange situations with preschool children (Crittenden et al., 2007). The PAA was coded by two coders according to Crittenden (2004). One of the coders had research-level reliability. One dyad was also classified by P.M. Crittenden. For further information of the assessment methods, see Farnfield et al. (2010).

Data analysis

The process of this study was inductive and tightly linked to the data. The aim of the multiple-case study is to understand the meaning of the circumstances within cases though an exploratory case study cannot generate causal relations (Eisenhardt, 1989). First, the transcribed AAIs were coded. In terms of Crittenden (2016a), the focus was on the dangers in the familial relationships, the self-protective strategies which the parents had developed to cope with the dangers in their families of origin and the effectiveness of the strategies. Not only the self-protective strategies, but also the unresolved traumas and losses of the parents (Syrjänen et al., 2018) were hypothesized to be discerned in their interaction with their child impacting their capacity to comfort their distressed infants (Schechter, 2017; Shah et al., 2014). As the analysis proceeded, it became clear that also intra-psychic dangers (Busch, 2005) had to be considered, that is, the internal(ized) conflicts that the dismissal of fear, desire for comfort or anger secondarily may generate (Busch, 2005). These may originate from particular restrictions and distortions in the parent-child affective dialogue, e.g. the parent does not respond empathically to or may even punish bids for comfort (see Lyons-Ruth,

1999). Also these defensive intra-psychic conflicts should be viewed as interactive and adaptive in origin. In information processing terms, the child learns to omit certain types of cognitive or affective information (Bowlby, 1980; Crittenden, 2016a).

Second, the CARE-Index, SSP and PAA were coded by a coder blind to the dyads and the AAI assessments. After the coding of all the assessments and becoming familiar with each dyad, cross-case patterns (Eisenhardt, 1989) were sought with the help of the analysis of the discourse and the history that was presented in the AAI transcripts of the parents. Cross-case patterns were also sought in regard to the connections between the self-protective strategies of the parent and the child, looking at parental sensitivity as a mediator.

Findings

Although some of the parents displayed a limited ability to protect and comfort their child, there was a great variation in the parents' self-protective strategies. Low, moderate and high-risk subgroups were formed in terms of the developmental risk that the transformations of information by the parent, as indicated by the DMM AAI discourse, created for their children.

The low-risk subgroup

Two parents displayed emergent reorganization in regard to attachment, IO(R) (insecure other, partial reorganization) and an adequate sensitivity level with their child. IO means Insecure Other, that is, the dysfluencies of speech and distortions of thought do not fully fit the DMM attachment patterns (Crittenden and Landini, 2011). Their children's self-protective strategies were in the normative range (see Table I). Still, the parents displayed indications of unresolved traumas that momentarily could interrupt their psychological functioning. Although they could articulate being drawn into triangulated family situations and wanted to reverse their family constellation with their own children, they were not yet able fully to evaluate the impact of family discord and triangulation on their own development. However, they were able to keep the protection of their children in their mind.

P2 and his son Nils. Although P2 was able to describe early emotional neglect by his hardworking parents, he displaced the trauma to his siblings. His feelings of worthlessness were connected to earlier emotional abuse by his father, who had told him as he was younger that he was "good for nothing." In addition, as a child, he appeared to have been drawn into the triangulated, schismatic spousal relationship. In the PAA, Nils displayed both coy and resistant behaviors. When P2 left the room, Nils did not look after him, dismissing him, until the door had closed. Only after that he looked at the door. Nils was anxious, but did not show it to his father. When Nils was alone, time seemed to stop and he repeated a sweeping mechanic movement with a toy in his hand. He did not display relaxed or happy facial expressions, but frowned at his father at the reunions in contrast to his father's disarming positive affect. Nils did not show proximity-seeking in the reunions, but he sought closeness already in the pre-separation episodes. Nils engaged both his father and the Stranger to support his play.

P4 and her daughter Annina. P4 was still preoccupied by and sad about the domestic violence perpetrated by her father on her mother. She often returned to the theme in the AAI and expressed a strong wish to reverse it with her own children. Genuine sadness appeared in the AAI about things that had happened and still happened in her family of origin and that could not be changed. In the PAA, P4 displayed a low-key communication (sitting relatively motionless with a rather still face). Mostly she left the initiation of activities to her daughter and Annina liked to be in control. Still, because P4 was able affectively to connect to her own

feelings, i.e., she could feel the fear and anger connected to the adverse childhood experiences, she was able to keep her daughter's needs in her mind being psychologically available.

Table 1. The sample characteristics (the low-risk group)

Parent Gender	**AAI Classification**	**Child Gender**	**CARE-Index Age of the child Parental sensitivity**	**PAA Age of the child Classification**
P2 M	IO(R) Utr(dpl)EN Utr(p)EA Utr(p)PC	Nils M	36 months sensitivity: 7	36 months C1-2
P4 F	IO(R) Utr(p)DV	Annina F	31 months sensitivity: 7	31 months C2

Note. IO(R)=Insecure other, partial reorganization; Utr(dpl)EN=displaced trauma of emotional neglect; Utr(p)EA=preoccupied trauma of emotional abuse; Utr(p)PC=preoccupied trauma of parental conflicts; Utr(p)DV=preoccupied trauma of domestic violence; C1-2=threatening-disarming; C2=disarming.

The moderate-risk subgroup

Two mothers had self-protective strategies in the moderate risk range, interrupted by unresolved traumas and losses. P3 displayed sensitivity in a risk range and P5 on the border to inept. However, their children had been able to develop self-protective strategies in the moderate risk range, in order to cope with and channel their anxiety related to maternal rejection and lack of comfort (see Table II).

P3 and her son Robin. P3 was interviewed with the AAI and video filmed for the Infant CARE-Index with her son, Robin, when he was 7 months old, and for the Toddler CARE-Index and the PAA, when Robin was 28 months old. P3 used a triangulated punitive-seductive strategy (C5 6), interrupted by unresolved traumas and early losses. In the CARE-Index, P3 was very uncomfortable to Robin's physical proximity-seeking, e.g. when Robin touched her long hair, she rejected him, which may also reflect her preoccupied trauma in regard to sexual and physical abuse as told in the AAI. P3 preferred an independent boy, and Robin was learning that proximity-seeking would cause rejection. The coders predicted that Robin's developmental pathway would be up to compulsively self-reliant strategy (A6). He had to separate early, i.e., learn the psychological boundaries with his mother, even though the mother did not sufficiently support his individuation (Mahler et al., 1975). Because of P3's needs of self-protection, she was not able to mobilize an interest in Robin's intentional world or mirror positively his unique characteristics. Robin risked fall out of his mother's mind most of the time, and he had to work hard to get her attention. Thus, P3 was not affectively engaged, showing some control in offering toys not at all connected to what Robin was doing at the moment.

In the PAA, Robin seemed to be a competent little boy, also when left alone. He looked older than his age and displayed both compulsive caregiving (A3) and performance (A4) and

evolving compulsive self-reliance (pA6). Robin established a play of cooking and serving food and he took care of his mother and fed her, thus, reversing the roles. Robin also took the responsibility for keeping up the play. The superficial first impression was positive, but it was the child, who did the work. P3 treated Robin as a caregiver, smiled at him and was proud of his competence. Under the surface of self-reliance, Robin's anxiety level appeared high. When he felt frustrated by his mother, he displaced his anger on the Pooh Bear doll beating it and throwing it away, as if saying: I do not want you, Pooh Bear! In addition, P3's handling of Robin's body, when undressing him, had a harsh and irritated quality. However, Robin had been able to adapt to the consistent rejection by developing a Type A+ strategy that worked with his mother. Robin did not show any indications of unresolved trauma, because he had been able get the attention of his mother with his self-protective strategy.

P3 and her daughter Manuela. P3 also took part in the SSP with her 14 months old daughter Manuela. Already in the pre-separation Episode 2 in the SSP, Manuela appeared aroused. She explored and moved restlessly on the floor, regularly slipping down, but without complaining. Manuela channeled her arousal in restless walking around. Also the mother's arousal was high. She had a stern face, the foot and fingers were twisting, but her face and voice were softer than with Robin. In the pre-separation episodes, Manuela went to the door, as if seeking a safer context and P3 had to call her back a few times. Manuela wanted to leave the room even though her mother was in the room and showed it to her mother. Thus, she was not afraid of her mother. When the Stranger entered, Manuela smiled at her and initiated contact with her. Manuela uttered squeaky vocalizations and displayed false positive affect. When together with the Stranger, Manuela walked two times to explore the rubbish bin, even though she was forbidden to do that. She did not use her mother or the Stranger to calm herself down and defend herself against her strong anxiety. Manuela displayed signs of compulsive inhibition (stiff body, stumbling without crying, not seeking comfort, open mouth, but no sounds or squeezed sounds) and evolving compulsive caregiving strategy (pA3). She also displayed bits of Type C behavior (trying to leave the room and explore the dust bin, though she had been forbidden by her mother and the Stranger), but these behaviors were not accompanied by any provocative looks or vocalizations. The coders agreed on an ongoing reorganization from evolving compulsive A strategy toward C.

P3 showed some interest in how Manuela felt. Though, feeling distressed P3 confused herself with her daughter. On both reunions in the SSP, she asked her daughter: "Where have you been?" as if Manuela was the person, who had left the room. Was Manuela a container of her mother's projective identifications in an enmeshed relationship? Or did P3 become confused about who was who, as she tried to self-regulate in the wake of the revival of traumatic losses at expense of being able to engage in mutual regulation of arousal (Schechter, 2017)? An indication of Manuela's traumatically skewed inter-subjectivity with her mother was her relatively high level of arousal. According to Schechter (2017), the infant's anxiety and anger may become dysregulated, which may further trigger the mother's anxiety and avoidance creating a vicious cycle that may contribute to the intergenerational transmission of trauma. If so, also Manuela might at times confuse her own perspective with that of her mother.

The children of P3, Robin and Manuela, had qualitatively different relationships with their mother. In family systems perspective, except for Type B, later-born children are unlikely to use the same strategy as the first-born child. In particular, in families at risk, the children have to find strategies that function most protectively in the context of their family system (Pocock, 2010). Robin was compelled by his mother's consistent rejection to separate early and manage his own affective self-regulation, gradually developing a compulsively caregiving

and evolving self-reliant strategy with P3, who took pride in her competent son. Manuela was apparently kept in a closer relationship, in which P3 at least from time to time showed some interest in Manuela's intentional world and could keep her daughter in her mind for a moment, paralleled by confusing herself Manuela, when stressed. However, also Manuela could occasionally drop from her mother's mind, maybe because of P3's trauma-related attentional lapses. This may have contributed to Manuela's traumatically skewed inter-subjectivity with her mother. In these situations, Manuela was compelled to use compulsive and, in particular, bits of obsessive strategies to engage her mother in which she succeeded.

P5 and her daughter Augusta. P5, Augusta's mother used a triangulated punitive-seductive strategy (C5-6), modified by many unresolved traumas. In the SSP, Augusta displayed evolving compulsive caregiving (pA3) and performance (pA4-) strategies and kept the interaction going. Augusta was a competent, verbally talented child repeating words she heard and she tried to understand what her mother and the stranger were speaking. She first cried, when she was left alone, but then she tried in a focused and skillful way to open the door. When she did not succeed, she was able to soothe herself by putting her finger in her mouth. Neither did she display any negative affect toward her mother, nor try to share feelings with her mother at the second reunion.

Table 2. The sample characteristics (the moderate-risk group)

Parent Gender	**AAI Classification**	**Child Gender**	**CARE-Index Age of the child Parental sensitivity**	**SSP/PAA Age of the child Classification**
P3 F	C5-6Δ Ul(p,dpl)F Utr(p)SA by SF Utr(p,ds)PA by SF, BF	Robin M	7 months 28 months sensitivity: 4	- 28 months A3-4-(pA6)
P3 F	C5-6Δ Ul(p,dpl)F Utr(p)SA by SF Utr(p,ds)PA by SF, BF	Manuela F	-	14 months R(pA+->C)
P5 F	C5-6Δ Utr(p)EA,PA Utr(p,dpl)CSA by a relative	Augusta F	13 months sensitivity: 5	13 months pA3,4-

Note. C5-6Δ=Punitive-seductive, triangulated strategy; Ul(p,dpl)F=preoccupied and displaced loss of father; Utr(p)SA by SF=preoccupied trauma of sexual abuse by step-father; Utr(p,ds)PA by SF, BF= preoccupied and dismissed trauma of physical abuse by step-father and boyfriend; Utr(p)EA,PA=preoccupied trauma of emotional and physical abuse; Utr(p,dpl)CSA by a relative=preoccupied and displaced trauma of childhood sexual abuse by a relative; A3-4-(pA6)=compulsive caregiving and compulsive performance and partial pre-self-reliance; R(pA+->C)=reorganization from pre-compulsive caregiving toward C; pA3,4-=pre-compulsive caregiving and pre-compulsive performance.

The high-risk subgroup

Two mothers displayed sensitivity and utilized self-protective strategies in the high risk range, for one of the mothers, broken by the modifier disorientation (DO) and for both interrupted by unresolved traumas. The children had not been able to develop fully functional self-protective strategies. The complexity of the self-protective strategies of the children reflected that of their mothers (see Table III). The mothers' distortion of information appeared at the procedural level as marked non-contingent responsivity and a conspicuous lack of affective attunement (Lyons-Ruth, 1999). The assessments are presented in an elaborated form, because of the great complexity of the interaction and the self-protective strategies.

P1 and her son Henry. P1 showed a disoriented blended compulsive caregiving (A3) and aggressive (C3) strategy and her sensitivity was in the high risk range, whereas her son displayed a generalized compulsive A+ strategy with intrusions of negative affect. During all the assessments, P1 talked in an excessive flow of words. She acted out her anxiety by speaking rapidly and excessively. Henry was confused, and it was difficult for him to follow his mother. Henry tried compulsively to follow his mother, but he was not able to contain his own high anxiety with the help of it. His anger leaked out in growling sounds and restless movements. He was not able to verbalize his feelings to his mother or to regulate his arousal with the help of language. He was silent and delayed in his language development. As P1's unpredictable and elusive behavior was not contingent on Henry's behavior, she was a blurry target for her child.

Why had P1 and her son Henry not been able to develop organized self-protective strategies? Indications of several traumas were found in the P1's DMM AAI. She portrayed a highly triangulated family with two schismatic parents, most of the time fighting and derogating each other, and herself balancing between them as the caregiving go-between. Both parents, her temperamental mother and alcohol abusing father, physically and emotionally abused their children, the full impact of which she denied. Trauma is the absence of mentalization of emotionally painful experiences of helplessness, intense fear and anger (Ensink et al., 2014), and, for this reason, experienced only on the level of procedural and imaged memory in connection with high arousal that can be coped with even by dissociation. P1 told in the interview that she was amazingly patient with her son, because when Henry was crying in her arms, she did not feel anything. He could go on crying for a long time, but she was patient. Thus, P1 was not able to interpret and give meaning to Henry's crying in order to console him. Instead she described a nearly affectively dissociated state. P1 had not learnt in her early attachment relationships to articulate and make sense of her negative affect, which left her psychic stage free for free-floating anxiety, that she most of the time acted out. In terms of Crittenden's (2016a) gradient of interventions, P1 would need individual psychotherapy, a relationship with a sensitive psychotherapist that would help her to understand the traumas that triggered her anxiety, to articulate and verbalize negative affect and recognize discrepancies. If she would understand her motives better through the experience of being understood empathically, she could recognize the needs of her child and would be able to respond to him more sensitively. Because Henry was not able to predict his mother or satisfy her with any behavior, he could fall prey for feelings of futility and being an object of outer forces. His current compulsive A+ strategy was not fully operational, one outcome of which were the intrusions of anger in both low-stress and moderate stress conditions.

P6 and her daughter Ewa. Ewa was un-kept in comparison to her very well-kept, fit and trimmed mother. When they came to the Toddler CARE-Index and the PAA, Ewa had no mittens, nor a hat, even though the weather was cold and snow was falling. The mother

explained that Ewa had refused. This could be interpreted as physical neglect. The mother was not engaged in the physical protection of her child.

P6's delusional idealization strategy (A7) was paralleled by her daughter's complex reorganization from C+ toward A+. During the Episode 2 in the PAA, Ewa at first tried to be self-reliant playing on her own talking to herself with a bright voice, at the same time looking with a promiscuous and seductive smile to the camera, as if she tried to attract the attention of strangers. She tried to use both feigned helpless and some coercive actions, but she was not able involve her mother even in a struggle. In fact, in the PAA she used anything to involve her mother, and there were only short moments of doing nothing, when Ewa was at a loss what to do, how to involve her mother next. In the beginning of the Episode 5, Ewa claimed that she had to visit the toilet. When her mother tried to delay it, Ewa said that she will pee in her pants. The mother asked out in the air "what shall we do now?" and they were permitted to visit the toilet. (Before the PAA Ewa had been asked, if she would like to visit the toilet, and she had refused). After their return, Episode 5 was started anew and the PAA proceeded in accordance with the guidelines. The urgent demand for a toilet visit was probably an indication of both Ewa's intruding high anxiety and coercive strategy. Ewa tried to initiate a struggle in the last episode. She asked to get toys and do things that were not accessible in the room. The function may have been to engage her mother to solve the problem or compel her mother to leave the room. Ewa's mother was not drawn into the struggle and Ewa switched to a compulsive caregiving (A3) strategy, uttering in a bright voice: "Look, there are the ponies," and they started, in the lead of Ewa, to look at the ponies. Ewa captured the attention of her mother again for a short moment.

The danger for Ewa was not being able to catch the attention of her minimally affectively attuned mother, who appeared almost "dead." The problem may originate from earlier failed interaction processes. In terms of Winnicott (1974,/1989), Ewa's feeling of going-on-being may have been be compromised, when she has not, as a baby, been able to reach her mother. Because of the risk of feeling non-existent, psychologically annihilated, lacking continuity-in-being, Ewa was desperate to maintain her mother's attention, trying in several ways to elicit any responses from her mother (Winnicott, 1974/1989). Ewa used passive, feigned helpless strategy doing silly things deliberately that slightly amused her mother and made the mother instruct her. In addition, Ewa showed anger (face, position) using a threatening strategy, but it did not create a struggle. Ewa's mother could not be engaged in struggle. Even though Ewa could get her will through, she was not able to engage her mother with a coercive strategy, because of her mother's lack of engagement. Ewa also displayed some disarming behaviors (face, voice and posture), but her C+ strategy did not function, because she was not able to involve her mother. Still Ewa did not display feelings of futility indicating depression. Instead she had started to develop a compulsive caregiving (A3) strategy to catch the attention of her retreating mother, e.g., Ewa appeared to cheer up her mother by doing silly things and looking seemingly stupid. The further the mother is in retreat, the longer the child has to go in approach to make the mother aware of her (Crittenden, 2016c). Thus, the C3-4 strategy did not work any longer and could not elicit responses from her mother. Ewa was developing a compulsive caregiving (A3) and evolving compulsive self-reliant (pA6) strategies in order to connect to her mother.

On the surface, Ewa's mother's greatest felt danger was that her anger would break through and she would not be able to control it, and keep up the façade of "normality." In parallel with her daughter, a more-seated deep fear was the experience of her own affective emptiness. P6 might fear that she was not able to go on being, connected to fears of psychological annihilation (Winnicott, 1974/1989). She had to get mirrored in the eyes of

other persons in order to know who she was and what she felt. P6's capacity to inhibit negative affect is both a strength and limitation. The strong inhibition may help her to go on, at least "robot"-like with her everyday life, especially, if her daughter keeps her fully preoccupied. The strong denial of any negative affect results in numbness, feelings of hollowness. Her earlier drug addiction and impulsive acting out during adolescence represent intrusions of negative affect and may have been attempts at avoiding the painful feelings of inner death, numbness and worthlessness. The treatments so far appear to have had iatrogenic effects, as these had aimed at increasing her already excessive self-control.

If the situation continues like this, it will be difficult for Ewa to develop self-determination and she will gradually proceed from the C+ strategy in direction of A+ including risks of loneliness and victimization. However, P6 showed an opening to reflective functioning in the AAI, when she, responding to the last question, tried to analyze the press on normality in her family of origin. Her mother, Ewa's grandmother, liked to keep the family façade polished and shining. P6 was considered a shame for the family. However, P6 stated that she herself abhorred polishing family facades, and she stressed that one should not feel ashamed, if one does not succeed in the way expected. Instead one should talk about it. Even though P6 criticized family values in the AAI only on the level of semantic generalizations, this indicated that she has started to understand that everything was not that perfect as it appeared to be and she was not that bad that she appeared to be in her family of origin. This insight is a start for a therapeutic dialogue.

Table 3. The sample characteristics (the high-risk group)

Parent **Gender**	**AAI** **Classification**	**Child** **Gender**	**CARE-Index** **Age of the child** **Parental sensitivity**	**PAA** **Age of the child** **Classification**
P1 F	DO A3 C3 Utr(p,ds)PA,EA Utr(dn)EN Utr(p)DV	Henry M	17 months 21 months 40 months sensitivity: 2	- 21 months 40 months A+[INA]
P6 F	A7 Utr(dn)EN Utr(dn) paternal anger Utr(dn)taken into custody	Ewa F	32 months sensitivity: 2	32 months C3-4->A3(pA6)

Note. DO A3 C3=blended compulsive caregiving and coercive aggressiveness, modified by disorientation; Utr(p,ds)PA,EA=preoccupied and dismissed trauma of physical and emotional abuse; Utr(dn)EN=denied trauma of emotional neglect; Utr(p)DV=preoccupied trauma of domestic violence; A7=delusional idealization; Utr(dn)paternal anger=denied trauma of paternal anger; Utr(dn)taken into custody=denied trauma of being taken into custody; A+[INA]=pervasive A+ structure with intrusions of anger; C3-4->A3(pA6)=changing from aggressive and feigned helpless toward compulsive caregiving and partial pre-compulsive self-reliance.

Discussion of the findings

The present study showed the variety of the self-protective strategies of parents with ADHD (see also Syrjänen et al., 2018, 2019). Also their children utilized a variety of self-protective strategies, the children's strategies matching those of their parents in regard to the degree of transformation of information. This match was mediated by the level of parental sensitivity in the dyadic interaction with their children. The more self-protective and complex the parents' strategies were the less sensitive was the interaction, which made it difficult for the children to make sense of their parents' behavior. Thus, the study demonstrated the unique ways of the transmission of attachment in a sample of parents with ADHD, in which a simple match or reversal patterning across generations is less probable than in a normative that is an average sample (Hautamäki et al., 2010; Verhage et al., 2016). Instead the children's strategies matched those of their parents in regard to complexity that is the degree of distortion of information.

In the low-risk group, the partially reorganizing parents were able to verbalize dangerous and traumatic experiences in their families of origin, both being drawn into schismatic spousal relationships connected to their parents slandering each other, for one of them accompanied by domestic violence (Syrjänen et al., 2018). As parents, they had been able to change some of the dysfunctions in their family of origin, that is, to create a family situation in which their children did not witness domestic discord or were drawn into triangulated family relationships. In contrast to reversal parenting (Crittenden and Landini, 2011; Hautamäki et al., 2010), they had been able, not only semantically, but also on the level of procedural and sensory memories (Crittenden and Landini, 2011), to protect their children, and create an adequately sensitive relationship to them for an attachment strategy (C1-2) in the normative range to evolve. Traumas in regard to dismissed early emotional neglect and preoccupied emotional abuse, might, however, still interrupt their behavior in inexplicable ways.

In the moderate-risk group, the parents' need for self-protection compromised their ability to protect and comfort their children by using clear signals. They had more complex self-protective strategies and unresolved traumas could still interrupt their behavior in inexplicable ways. However, the children in the moderate-risk group had been able to adapt to their parents caregiving behavior by developing complex, but fully operational self-protective strategies.

In the high risk group, the parents protected more themselves than their children, i.e. lacking in predictable protection, comfort and clarity of communication. The children had developed complex, not even fully operational self-protective strategies in line with the results of Landini et al. (2016). Because of their mothers' minimal contingent responsivity and affective attunement the children did not feel themselves recognized, that is "sensed" and "known," in particular, when they were distressed. According to Beebe and Steele (2013, p. 598), "These profound experiences of non-recognition may disturb the infant's core sense of safety." In the high-risk group, the internal dangers felt by both children might be connected to falling apart, psychological annihilation, not being able to go on being in terms of Winnicott (1974/1989). This elicits an intense anxiety that is immediately acted out in general gross-motor activity. Winnicott (1965) stresses that if mother is not able to carry out the ego-supportive auxiliary function of creating continuity of being, then the baby does not come into personal existence feeling real. Instead, the baby builds up a false self, structured by the environmental impingements. The breakdown in continuity of being results in a defense organization with the function to cope with the primitive agony of falling apart, being psychologically annihilated (Ogden, 2014). According to Winnicott (1965), the resulting

pattern of fragmentation of being may be found in the psychological aetiology of restlessness, hyperkinesis and inattentiveness.

Implications for treatment

For the adult respondents of this study, the diagnosis ADHD did not give differentiated guidelines for adequate intervention. Though all but one of the parents with ADHD had received the same medical treatment, they displayed within-diagnosis heterogeneity. They differed in regard to their self-protective strategies including different degrees of distortion of information, which was linked to varying sensitivity and child strategies. All parents showed indications of unresolved traumas interrupting the strategic functioning momentarily. The traumas were connected to a triangulated family system in the parents' family of origin. Thus, any treatment must take into account the self-protective strategies of these parents with ADHD and the children, the traumas of the parents as well as the modifiers, in particular, disorientation. All of these families would benefit from a family psychological assessment, assessments of the self-protective strategies of both the parents and children making possible a treatment tailored to the unique family needs (Crittenden et al., 2014). All these parents would benefit from individual psychotherapy, in which they would get the emotional support to learn to identify and articulate their feelings and encourage open communication of their relationships with other family members in their family of origin, in particular, exploring triangular processes and the part they themselves played in the family. As the parents had not worked through their traumas, psychotherapy must at start focus on the regulation of their arousal by working with traumas (Landini, 2014).

For example, in order to avoid the risk of new intrusions of negative affect and a relapse into drug addiction, P6 would need individual psychotherapy in which she could access her negative affect, in particular, her anger without fearing a breakdown. In terms of Ogden (2014), she would need help with learning to feel continuity-in-being with a psychotherapist who could contain her early annihilation anxieties. Any intervention must help her to feel more alive by gradually accessing and connecting to her negative affect, to help her to contain and verbalize it (Ogden, 2014) and strengthen her core identity. Gradually, she also would need help in processing the negative feelings connected to her scape goat position in her triangulated family of origin, a position that she still has. She had, in fact, accepted her role as the deviant, less worthy child and felt bad about herself in comparison to her idealized parents and her more successful siblings. This would also help her to become more self-determined, independent and critical in regard to her own, highly idealized parents and to change her distanced and unresponsive relationship with her daughter Ewa. She would become more protectively available to Ewa and establish a more assertive authority relationship to her daughter. Ewa could gradually learn to cope with her mother with self-protective strategies in the normative ABC range, characterized by less distortions of information (see Farnfield et al., 2010: Dynamic Maturational Model of self-protective strategies in adulthood). Only the partially reorganizing parents would benefit from video-feedback (see Crittenden, 2016a). In addition, they would also be helped by an individual psychotherapy in order to support their attachment reorganization in the zone of their potential development.

Limitations

This is a small-scale exploratory multiple-case study that at best can demonstrate new ideas to be tested with quantitative methods in larger samples. One of the main limitations was the small sample size due to difficulty in recruiting the hard-to-reach group using specific inclusion and exclusion criteria. The results should be generalized with caution. In addition,

the data were collected using time consuming, in-depth attachment assessments requiring extensive training. Still, the size and the quality of the data were good enough for the exploratory purpose of this study. The present study offered a heuristic hypothesis about how self-protective strategies were transmitted, as mediated by parental sensitivity, in a sample of parents with ADHD to their children (Landini et al., 2016). The children's strategies matched that of their parents in regard to complexity that is the degree of distortion of information.

In contrast to the AAI, the CARE-Index, the SSP and the PAA do not assess traumas. Thus, the impact of the parents' traumas and losses on their children could not be directly assessed, only inferred indirectly from observed interaction, in particular, in terms of traumatically skewed intersubjectivity (Schechter, 2017) that may, however, originate both from the parents' trauma and/or self-protective strategy. The effect on the child of feeling unprotected and uncomforted depends, in turn, on the child's ability to cope with his self-protective strategy with his heightened arousal. If the stressor exceeds his coping capacity, trauma ensues.

References

Ainsworth, M.D.S., Blehar, M.C., Waters, E. and Wall, S. (1978), *Patterns of Attachment: A Psychological Study of the Strange Situation*, Lawrence Erlbaum, Hillsdale, MI.

American Psychiatric Association (2000), *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., American Psychiatric Association, Washington, DC.

Beebe, B. and Steele, M. (2013), "How does microanalysis of mother–infant communication inform maternal sensitivity and infant attachment?", *Attachment & Human Development*, Vol. 15 Nos 5-6, pp. 583-602.

Bowlby, J. (1980), *Attachment and Loss. Vol 3: Loss: Sadness and Depression*, Basic Books, New York, NY.

Busch, F. (2005), "Conflict theory/trauma theory", *The Psychoanalytic Quarterly*, Vol. 74 No. 1, pp. 27-45.

Chronis-Tuscano, A., Raggi, V.L., Clarke, T.L., Rooney, M.E., Diaz, Y. and Pian, J. (2008), "Associations between maternal attention-deficit/hyperactivity disorder symptoms and parenting", *Journal of Abnormal Child Psychology*, Vol. 36 No. 8, pp. 1237-50.

Clarke, L., Ungerer, J., Chahoud, K., Johnson, S. and Stiefel, I. (2002), "Attention deficit hyperactivity disorder is associated with attachment insecurity", *Clinical Child Psychology and Psychiatry*, Vol. 7 No. 2, pp. 179-98.

Crittenden, P.M. (2004), "*The preschool assessment of attachment: coding manual*", unpublished manuscript, Family Relations Institute, Miami, FL.

Crittenden, P.M. (2005), "*CARE-Index – Toddlers: coding manual*", unpublished manuscript, Family Relations Institute, Miami, FL.

Crittenden, P.M. (2010), "*CARE-Index – Infants: coding manual*", unpublished manuscript, Family Relations Institute, Miami, FL.

Crittenden, P.M. (2016a), *Raising Parents: Attachment, Representation, and Treatment*, 2nd ed., Routledge, London and New York, NY.

Crittenden, P.M. (2016b), "*A guide to the Ainsworth Infant Strange Situation with expansions and modifications*", unpublished manuscript, Family Relations Institute, Miami, FL.

Crittenden, P.M. (2016c), "Personal communication with P.M. Crittenden", May 2016.

Crittenden, P.M. and Kulbotten, G. (2007), "Familial contributions to ADHD: an attachment perspective", *Tidsskrift for Norsk Psykologforening*, Vol. 44 No. 10, pp. 1220-9.

Crittenden, P.M. and Landini, A. (2011), *Assessing Adult Attachment. A Dynamic-Maturational Approach to Discourse Analysis*, W.W. Norton & Company, New York, NY and London.

Crittenden, P.M., Claussen, A.H. and Kozlowska, K. (2007), "Choosing a valid assessment of attachment for clinical use: a comparative study", *Australian and New Zealand Journal of Family Therapy*, Vol. 28 No. 2, pp. 78-87.

Crittenden, P.M., Dallos, R., Landini, A. and Kozlowska, K. (2014), *Attachment and Family Therapy*, Open University Press, Berkshire, NY.

Dallos, R. and Smart, S. (2011), "An exploration of family dynamics and attachment strategies in a family with ADHD/conduct problems", *Clinical Child Psychology and Psychiatry*, Vol. 16 No. 4, pp. 535-50.

Deault, L.C. (2010), "A systematic review of parenting in relation to the development of comorbidities and functional impairments in children with attention-deficit/hyperactivity disorder (ADHD)", *Child Psychiatry and Human Development*, Vol. 41 No. 2, pp. 168-92.

Eisenhardt, K.M. (1989), "Building theories from case study research", *The Academy of Management Review*, Vol. 14 No. 4, pp. 532-50.

Ellis, B. and Nigg, J. (2009), "Parenting practices and attention-deficit/hyperactivity disorder: new findings suggest partial specificity of effects", *Journal of the American Academy of Child & Adolescent Psychiatry*, Vol. 48 No. 2, pp. 146-54.

Ensink, K., Berthelot, N., Bernazzani, O., Normandin, L. and Fonagy, P. (2014), "Another step closer to measuring the ghosts in the nursery: preliminary validation of the trauma reflective functioning scale", *Frontiers in Psychology*, Vol. 5 No. 1471, pp. 1-12.

Epstein, J., Johnson, D. and Conners, C. (2001), *Conners' Adult ADHD Diagnostic Interview for DSM-IV (CAADID)*, Multi-Health Systems, Toronto.

Farnfield, S., Hautamäki, A., Nørbech, P. and Sahhar, N. (2010), "DMM assessments of attachment and adaptation: procedures, validity and utility", *Clinical Child Psychology and Psychiatry*, Vol. 15 No. 3, pp. 313-28.

First, M.B., Spitzer, R.L., Gibbon, M. and Williams, J.B. (1996), *Structured Clinical Interview for DSM-IV Axis I Disorders*, American Psychiatric Press, Inc., Washington, DC.

First, M.B., Gibbon, M., Spitzer, R.L., Williams, J.B. and Benjamin, L.S. (1997), *Structured Clinical Interview for DSM-IV Axis II Personality Disorders*, American Psychiatric Press, Inc., Washington, DC.

George, C., Kaplan, N. and Main, M. (1985), "*Adult attachment interview: interview protocol*", unpublished manuscript, Department of psychology, University of California, Berkeley, CA.

Hautamäki, A., Hautamäki, L., Neuvonen, L. and Maliniemi-Piispanen, S. (2010), "Transmission of attachment across three generations: continuity and reversal", *Clinical Child Psychology and Psychiatry*, Vol. 15 No. 3, pp. 347-54.

Hechtman, L. (1996), "Families of children with attention deficit hyperactivity disorder: a review", *The Canadian Journal of Psychiatry*, Vol. 41 No. 6, pp. 350-60.

Jensen, P.S., Mrazek, D., Knapp, P.K., Steinberg, L., Pfeffer, C., Schowalter, J. and Shapiro, T. (1997), "Evolution and revolution in child psychiatry: ADHD as a disorder of adaptation", *Journal of American Academy of Child and Adolescent Psychiatry*, Vol. 36 No. 12, pp. 1672-9.

Johnston, C., Mash, E.J., Miller, N. and Ninowski, J.E. (2012), "Parenting in adults with attention-deficit/hyperactivity disorder (ADHD)", *Clinical Psychology Review*, Vol. 32 No. 4, pp. 215-28.

Künster, A.K., Fegert, J.M. and Ziegenhain, U. (2010), "Assessing parent-child interaction in the preschool years: a pilot study on the psychometric properties of the Toddler CARE-Index", *Clinical Child Psychology and Psychiatry*, Vol. 15 No. 3, pp. 379-90.

Ladnier, R.D. and Massanari, A.E. (2000), "Treating ADHD as attachment deficit hyperactivity disorder", in Levy, T.M. (Ed.), *Handbook of Attachment Interventions*, Academic Press, San Diego, CA, pp. 27-65.

Landini, A. (2014), "Psychotherapists' and patients' dispositional representations of danger: Intervention planning using DMM assessments", in Hautamäki, A. (Ed.), *The Dynamic-Maturational Model of Attachment and Adaptation – Theory and Practice*, Vol. 37, University of Helsinki, SSKH Skrifter, Helsinki, pp. 72-101.

Landini, A., Crittenden, P.M. and Landi, G. (2016), "The parents of child psychiatric patients", *Annals of Psychiatry and Mental Health*, Vol. 4 No. 7, p. 1087.

Lyons-Ruth, K. (1999), "The two-person unconscious: Inter-subjective dialogue, enactive relational representation and the emergence of new forms of relational organization", *Psychoanalytic Inquiry*, Vol. 19 No. 4, pp. 576-617.

Mahler, M.S., Pine, F. and Bergman, A. (1975), *The Psychological Birth of the Human Infant*, Basic Books, New York, NY.

Main, M. and Solomon, J. (1990), "Procedures for identifying infants as disorganized-disoriented during the Ainsworth strange situation", in Greenberg, M., Cicchetti, D. and Cummings, E.M. (Eds), *Attachment in the Preschool Years: Theory, Research, and Intervention*, University of Chicago Press, Chicago, IL, pp. 121-60.

Murray, C. and Johnston, C. (2006), "Parenting in mothers with and without attention-deficit/ hyperactivity disorder", *Journal of Abnormal Psychology*, Vol. 115 No. 1, pp. 52-61.

Ogden, T.H. (2014), "Fear of breakdown and the unlived life", *The International Journal of Psychoanalysis*, Vol. 95 No. 2, pp. 205-23.

Pocock, D. (2010), "The DMM – wow! But how to safely handle its potential strength?", *Clinical Child Psychology and Psychiatry*, Vol. 15 No. 3, pp. 303-11.

Schechter, D. (2017), "On traumatically skewed intersubjectivity", *Psychoanalytic Inquiry*, Vol. 4 No. 1, pp. 251-64.

Semple, D., Mash, E., Ninowski, J. and Benzies, K. (2010), "The relation between maternal symptoms of attention-deficit/hyperactivity disorder and mother–infant interaction", *Journal of Child and Family Studies*, Vol. 20, pp. 460-72.

Shah, P., Fonagy, P., Allen, J. and Strathearn, L. (2014), "Mothers' unresolved trauma blunts amygdala response to infant distress", *Social Neuroscience*, Vol. 9 No. 4, pp. 352-63.

Spieker, S. and Crittenden, P. (2018), "Can attachment inform decision-making in child protection and forensic settings?", *Infant Mental Health Journal*, Vol. 39 No. 6, pp. 625-41.

Stiefel, I. (1997), "Can disturbance in attachment contribute to attention deficit hyperactivity disorder? A case discussion", *Clinical Child Psychology and Psychiatry*, Vol. 2 No. 1, pp. 45-64.

Storebø, O., Rasmussen, P. and Simonsen, E. (2016), "Association between insecure attachment and ADHD: environmental mediating factors", *Journal of Attention Disorders*, Vol. 20 No. 2, pp. 187-96.

Syrjänen, M., Hautamäki, A., Pleshkova, N. and Maliniemi, S. (2018), "Adults with ADHD – a retrospective account of the family systems and attachment relationships", *Clinical Neuropsychiatry*, Vol. 15 No. 2, pp. 123-31.

Syrjänen, M., Hautamäki, A., Pleshkova, N. and Maliniemi, S. (2019), "Attachment and sensitivity among parents with ADHD – a multiple-case study", *Emotional and Behavioural Difficulties*, Vol. 24 No. 2, pp. 156-66.

Thapar, A. and Cooper, M. (2016), "Attention deficit hyperactivity disorder", *Lancet*, Vol. 387 No. 10024, pp. 1240-50.

Verhage,M., Schuengel, C., Madigan, S., Fearon, R., Oosterman, M., Cassibba, R., Bakermans-Kranenburg, M.J. and van IJzendoorn, M.H. (2016), "Narrowing the transmission gap: a synthesis of three decades on intergenerational transmission of attachment", *Psychological Bulletin*, Vol. 142 No. 4, pp. 337-66.

Winnicott, D.W. (1965), *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*, International Universities Press, New York, NY.

Winnicott, D.W. (1974/1989), "Fear of breakdown", in Winnicott, C., Shepherd, R. and Davis, M. (Eds), *Psycho-Analytic Explorations*, Karnac Books, London, pp. 87-95.