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**Cultivating Curiosity and Collaboration:
Mentalizing as a Modality of Intervention in Attention-Deficit/Hyperactivity Disorder**

Danielle M. Bryson

Submitted in partial completion
of the requirements for the degree of
Master of Arts in Child Development
at Sarah Lawrence College, May 2020

Abstract

Parents and caregivers who are able to understand their own mental states are better able to hold a child's mental states in mind, an important consideration for moderating negative perceptions of ADHD behavior. In this thesis, I discuss how mentalizing-focused treatment for parents and caregivers strengthens attachment bonds in families where a child is diagnosed with ADHD. I explore the effectiveness of mentalizing-focused treatment to parents, some of whom experience difficulty in understanding their own mental states, and all of whom experience challenges in interpreting the intentions and mental states of their children, particularly in families where a child has been diagnosed with ADHD. In addition, I define how mentalizing relates to the important developmental theories, including attachment, as a means of promoting autonomy and resilience for a child as well as the potential negative effects when mentalizing breaks down.

Keywords: ADHD, mentalizing, reflective functioning, attachment, child development

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¹ Rich, 1991.

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**Cultivating Curiosity and Collaboration:
Mentalizing as a Modality of Treatment in Attention-Deficit/Hyperactivity Disorder**

Only if we understand, will we care.
Only if we care, will we help.
Only if we help, shall all be saved.
Jane Goodall (1999) Forty Years at Gombe

1. Introduction and Literature Review

A child enters the world ready to explore and to experience. Early interactions with a caregiver set the tone. Parents who are better equipped to manage the challenges of parenting are more able to stay connected to their children and to provide support to help their child manage their own hardships; this can be especially true for families where a child is diagnosed with ADHD.

Recent data estimates that 5-8% or 2.5-4 million school-aged children are diagnosed with ADHD; approximately one or two children with ADHD are in every classroom in the United States (Barkley, 2013). However, it is not only the US that reports cases of the disorder. The worldwide prevalence has now been established to be 4.5-5% of children and 3.5-4.5% of adults; Japan has identified up to 7% of children as having the disorder, China 6-8%, France up to 7%, and New Zealand up to 7% (as cited in Barkley, 2013). There are several other countries that are likely affected but have yet to acknowledge or report the prevalence of ADHD.

Studies regarding the family dynamic and ADHD have begun to highlight some of the challenges children and families face. Observational studies consistently find high levels of negative and controlling behaviors in both parents and their children with ADHD (Johnson & Mash, 2001). Johnston, Murray, Hinshaw, Pelham, and Hoza found that child conduct problems were uniquely associated with observed maternal responsiveness and sensitivity to the child in families of boys with ADHD, (as cited in Johnson & Mash, 2001). Mash and Johnston reported

that parenting stress in all domains was significantly elevated in mothers of children with ADHD, particularly mothers of preschool-age children. In addition, mothers' reports of parenting stress were related to observed difficulties in the interactions of children with ADHD and their siblings (as cited in Mash & Johnston, 2001). In order to facilitate proper therapeutic treatment for ADHD children and families, it is necessary to understand the facets of the disorder and to adopt a curious and supportive approach.

In this paper, I look at the ways in which mentalizing-focused treatment for parents strengthens attachment bonds in families where a child is diagnosed with ADHD. I will begin with an overview of ADHD. In order to explore the need for better therapeutic interventions for children and families of ADHD, it is important to consider ways in which the diagnosis affects the parent-child dyad and how the best course of treatment begins with parental awareness in order to form secure attachment bonds. Current therapeutic treatment of ADHD is primarily focused on behavior modification in the child because ADHD symptoms of inattention, impulsivity, deficits in executive functioning, and emotional lability are often challenging for parents in terms of interpreting the child's motivations. This can make it difficult for the parent to maintain positive representations of their child and to sustain secure connections with their child. The second section introduces case studies to illustrate why mentalizing is an important consideration in ADHD families. The third section describes mentalization and the theoretical framework behind this modality, specifically mirroring, object relations theory, and attachment theory and how this is an important consideration to facilitate secure bonds between parents and children. This section also discusses how parents can develop a reflective stance—including therapeutic interventions—to better support strong attachment relationships. The final section concludes with why reflective functioning is an important consideration for the treatment of ADHD and

discuss future areas of study which can support families so that generations of children diagnosed with ADHD are able to thrive.

What is ADHD?

Attention-deficit/hyperactivity disorder, or ADHD, is a developmental disorder that is most commonly characterized by inattention and impulsivity-hyperactivity. Features of ADHD are often noticeable in preschool-aged children, but it is often difficult to diagnose as symptoms can change as children mature. Children often behave differently in various contexts but collecting data on specific behaviors at school, home, and social settings can help a clinician to assess and effectively diagnose a disorder. Comprehensive neuropsychological tests can be performed during an evaluation to better support a diagnosis of ADHD.

The *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) apportions the diagnostic criteria in patterns of inattention or hyperactivity and impulsivity for at least six months in which at least six of nine criteria must be met—ages 17 and older require five criteria—to warrant a diagnosis. Examples of symptoms include: “difficulty sustaining attention in tasks or play activities” (inattention), “often fidgets with or taps hands or feet or squirms in seat” (hyperactivity and impulsivity), and “often talks excessively” (hyperactivity and impulsivity) (APA, 2013, pp. 59-60). Combined presentation, predominantly inattentive or predominantly hyperactive/impulsive should be specified in the diagnosis (APA, 2013). ADHD is more frequent in males than in females in the general population with a 2:1 ratio in children and 1.6:1 in adults. Females are more likely to present with inattentive features (APA, 2013).

Symptoms of ADHD may evolve over time, but it is worth noting that ADD [ADHD] is multifaceted. Drs. Edward M. Hallowell and John J. Ratey describe 13 subtypes of ADHD: ADD without hyperactivity, ADD with anxiety, ADD with depression, ADD with other learning

disorders, ADD with agitate or mania, ADD with substance abuse, ADD in the creative person, ADD with high-risk behavior, ADD with dissociative states, ADD with borderline personality features, ADD with conduct disorder, ADD with obsessive-compulsive disorder, and Pseudo-ADD (Hallowell & Ratey, 2011). Each child should be assessed as an individual with an understanding that symptoms may change or improve with time; maturity is an important consideration.

A major component of ADHD is executive functioning deficits. Executive functioning is an organizational tool of the brain that helps an individual to arrange tasks to facilitate the achievement of a specific goal. Paying bills on time and managing household tasks involves executive functioning. A child's ability to complete a homework assignment relies on executive functioning. A child's inability to manage themselves to effectively complete tasks often leads to low self-esteem because they think something is fundamentally wrong with them. People with ADHD may interpret this more as a personality flaw as opposed to a neurological disorder.

Another component of ADHD can include increased emotion. Definitions of rapid or unexpected changes in mood can be defined in many ways: emotional lability (EL), emotional reactivity, emotional impulsivity (EI), emotional instability, emotional dysregulation, deficient emotional self-regulation, distress tolerance, frustration discomfort and irritability (Faraone et al., 2019, p.133). Whatever the terminology, difficulty in emotion regulation often affects individuals with ADHD. Forty to 50% of children with ADHD have significant impairments that stem from rages, irritability, or other manifestations of susceptibility to anger and low tolerance for distress (Faraone et al., 2019, p. 133). These symptoms are more prevalent in the combined subtype (now called 'presentation' in DSM-5) of ADHD compared with other subtypes and their severity increases with the severity of other ADHD symptoms. Emotional symptoms are also

common among adults with ADHD (Faraone et al., 2019, p. 133). At present, emotional symptoms are not part of the core criteria for the ADHD diagnosis, but their prevalence and importance in terms of impairment cannot be overstated. Researchers are currently placing more importance on considering emotion symptoms as a core trait versus an associated trait especially because those experiencing intense emotions are less able to self-regulate (Faraone et al., 2019). It is important to consider that increased emotion can present itself as anger or extreme sadness or crying and can be frustrating for the person experiencing this overwhelming abundance of affect.

Contemporary concerns often ponder whether developmental disorders in children—such as ADHD—are over diagnosed in children. As the National Institutes of Health (NIH) Consensus Development Conference on ADHD concluded in late 1998, the surgeon general in a report on children’s mental health in the United States in 2002, the Centers for Disease Control and Prevention in the *National Health Interview Survey* in 2005, and NIMH again in the *National Comorbidity Survey Replication* in 2005 and 2010, it is an *underdiagnosis* and *undertreatment* of ADHD (and other disorders) in children that remain the big problems in the United States today (as cited in Barkley, 2013). In fact, fewer than 60% of all children who have ADHD are diagnosed or treated properly for the disorder and that only half or fewer of these are treated with medication (as cited in Barkley, 2013). Assertions that we are overmedicating or over diagnosing ADHD lack any rational proof. In most cases, children with genuine disorders are often not diagnosed or treated properly. Treatment and services can often be well below what standard care for the disorder should be; often times care is inconsistent and poorly managed.

The effects of ADHD to society are abundant: more than 20% of children with ADHD have set serious fires in their communities, more than 30% have engaged in theft, more than 40%

drift into early tobacco and alcohol use, and more than 25% are expelled from high school because of serious misconduct (as cited in Barkley, 2013). ADHD also affects driving for adolescents; young adults with ADHD report nearly four to five times as many citations for speeding and damages are two to three times more expensive (as cited in Barkley, 2013). Economists estimate that raising a child with ADHD results in more than twice the expense in medical bills of families with typical children, exclusive of treating the child's ADHD (as cited in Barkley, 2013).

In *Driven to Distraction*, Dr. Edward Hallowell quotes Dr. Russell Barkley: "ADD is more impairing than any syndrome in all mental health that is treated on an outpatient basis. More impairing than anxiety, more impairing than depression, more impairing than substance abuse" (as cited in Hallowell & Ratey, 2011, p. xv). ADHD is not a benign disorder to the child or to the potential costs to society. If left untreated, the costs can be even greater in terms of low productivity and unemployment. Economists consider the cost to society of a teenager's not graduating from high school will be between \$370,000 and \$450,000 in lost wages, taxes, and other contributions (as cited in Barkley, 2013).

Possible Neuropathology

There is no medical test that can be administered to test for ADHD, just as there is no sure-fire way to test for schizophrenia, bipolar disorder, alcoholism, Tourette syndrome, depression, anxiety disorders, or for many widespread medical disorders such as arthritis or the early stages of multiple sclerosis or Alzheimer's disease (Barkley, 2013). Just as the aforementioned dysfunctions are real, so too is ADHD. Although it may be difficult to pinpoint or quantify an exact cause of ADHD, studies of the brain and ADHD behavior have shed light on

potential sources. DSM-V categorizes ADHD along with other neurodevelopment disorders—as opposed to disruptive behavior disorders.

Scientific studies often show a consistent relationship between symptoms of ADHD and potential causes. For instance, animal studies have shown that ADHD affects the development of the prefrontal cortex of the brain which is believed to be responsible for executive functioning and self-regulation (as cited in Barkley, 2013). In these studies, primates performed psychological tests with a healthy brain. After surgical alteration to the prefrontal cortex of their brain, the primates' behavior patterns were consistent with children with ADHD. With the altered prefrontal cortex, the primates were hyperactive, less able to pay attention for long periods of time, and more impulsive on the psychological tests (as cited in Barkley, 2013). Social behavior was also affected in these studies. This research also proved that other areas of the brain—when altered—do not exhibit the same pattern of ADHD symptoms, so it can be determined that ADHD affects the prefrontal cortex.

Two primary factors are considered when assessing individuals with ADHD: environmental agents such as fetal exposure to alcohol and tobacco and heredity. Scientists have reported that people experiencing severe brain injuries to the front of the brain—trauma, tumors, strokes, diseases, or penetrating wounds—have been reported to exhibit symptoms similar to those diagnosed with ADHD, so a correlation can be made (as cited in Barkley, 2013). Considerations are also made for twins and for children with a low birth weight, especially less than 1500 grams or 3.31 pounds (as cited in APA, 2013).

Consumption of nicotine and alcohol during pregnancy have been shown to cause significant brain abnormalities in areas of the brain. A 1992 study—and more recent studies—found that direct exposure to cigarette smoke during pregnancy or indirect exposure after

pregnancy increased the odds of behavior problems in the children of these pregnancies (as cited in Barkley, 2013). Not only the prevalence but the quantity of nicotine consumption during pregnancy increases the chance that the fetus may develop ADHD. Scientific evidence suggests that mothers who smoke at least 10 cigarettes or more per day during their pregnancies increase the risk of ADHD in their children by 2.5 times the risk seen in the nonsmoking population (as cited in Barkley, 2013). Alcohol consumption during pregnancy has also been found to be a ADHD risk factor for the fetus. The risk of having a child with ADHD increases 2.5 times for women who drink during pregnancy over women who do not (as cited in Barkley, 2013).

ADHD is thought to be an inherited disorder. Evidence of this comes from studies that evaluate members of an immediate family when one of them is diagnosed with ADHD. A study published in 1990—conducted by Drs. Joseph Biederman, Stephen Faraone, and their associates at Massachusetts General Hospital—found that 25% of the first-degree relatives in the families of children with ADHD also had ADHD (as cited in Barkley, 2013). Scientific studies into the causes of ADHD are relatively new; many adults do not realize that they have ADHD, only that they have struggled with the symptoms for their entire lives. 90% of adults with ADHD do not know they have it (as cited in Hallowell & Ratey, 2011). It is only when a child in the family is diagnosed that other family members become aware that they share these traits with their children.

Recent scientific studies regarding the genetics behind ADHD are beginning to identify and decode ADHD genes. Scientists have been evaluating family members of a person identified as having ADHD and scanning the entire human genome to establish the number of genes involved in the disorder and their location (as cited in Barkley, 2013). Subsequent research then investigates the nature of the genes located at these sites so that we may begin to understand how

the gene functions in the human brain (as cited in Barkley, 2013). So far, 22-40 or more sites have been identified in these initial genome scans; some of the sites are known while some are still waiting to be identified (as cited in Barkley, 2013). Essentially it is understood that ADHD seems to be caused by multiple genes. If each of these genes is a contributing factor to ADHD, more or less of the genes may determine whether or not someone has ADHD and the severity of this disorder (the more genes, the more severe the symptoms). People without ADHD may still possess these genes, but individuals displaying ADHD symptoms may have mutations of the genes—longer or shorter (as cited in Barkley, 2013).

Several studies indicate alterations in two dopamine neurotransmitters—DRD4 and DAT1 genes—may be related to ADHD (as cited in Barkley, 2013). A longer variant in the gene DRD4 may make children and adults with ADHD less sensitive to dopamine so they require more of it to make their cells activate (as cited in Barkley, 2013). These individuals may exhibit more sensory-seeking, impulsive behavior that is often displayed in individuals with ADHD. DAT1 alterations—again the gene is longer—may also be linked to ADHD as a dysregulation of dopamine (as cited in Barkley, 2013).

Current Treatment

The first step in the treatment of ADHD is to obtain a proper diagnosis. Often the diagnosis can be an emotional experience for the parents of a child diagnosed with ADHD. Whenever a diagnosis of a developmental disorder is made with any child, most parents would tend to experience a sense of loss in relinquishing the vision of a prototypical future for their child. If the child struggles academically, how will they go to a top college? If the child lacks focus, how can they be the star of the baseball team? Does the parent also see a part of

themselves or family members in this child? Could this lead to negative parenting of the child because the fear a parent may have?

If the child is old enough to comprehend the diagnosis, sharing details of their diagnosis can be one of the most effective methods of treatment. Because ADHD children can often struggle with low self-esteem, it often helps for them to understand the disorder. Parents, doctors, and clinicians should emphasize that the ADHD diagnosis is not something the child has done wrong. Instead, explaining how the disorder may affect some of their processing and learning disabilities helps to de-stigmatize labels that may be associated with the disorder. Simple, supportive information allows them to feel appreciated for their unique strengths and qualities; this can help to motivate and sustain them through trying times.

There are many modes of treatment depending on the specifics of the ADHD diagnosis. Drs. Hallowell and Ratey outline ten tips on structuring and organizing the life of the child with ADHD. These include: identifying problem areas and providing remedies, concrete reminders, incentive plans, frequent feedback from parents (and teachers), assigning responsibility, using copious amounts of positive praise, considering the use of a coach or tutor, helping the child to implement various useful plans and devices, and remembering that negotiation is key (Hallowell & Ratey, 2011).

Medication is also a common form of treatment for ADHD. Medication may not work for some and it can take a few trials to verify what works best for the individual. There are instances where medication may not be successful in younger children. Still, for many it can make a hugely positive difference.

Stimulants are the most commonly used in the treatment of ADHD. One common stimulant medication used in the treatment of ADHD is methylphenidate such as Ritalin,

Concerta, Medadate CD, Focalin, and a skin patch called Daytrana (as cited in Barkley, 2013). The other common stimulant medication used is amphetamine which includes Dexedrine, Adderall, Adderall XR, and Vyvanse (as cited in Barkley, 2013). In some cases, antidepressants and non-stimulants can also be prescribed. Recent advancements in medication have made it possible for drugs to have longer lasting effects. In the past stimulants such Ritalin were taken once in the morning and again at lunchtime. Because of the advancements in the time release sequence of these drugs, only one pill is necessary but should typically be taken in the morning to avoid insomnia (Hallowell & Ratey, 2011).

Stimulants work to increase the activity of chemicals found naturally in the brain such as dopamine. Neurotransmitters such as dopamine are often found to be deficient in individuals with ADHD so the stimulants help to activate these chemicals which can improve behavior and focus (Hallowell & Ratey, 2011). Stimulants help about 80% of those diagnosed with ADHD (N. Weder, personal communication, 2017), but it is important to be aware of side effects. Some of the most common side effects of stimulants include decreased appetite, insomnia, irritability, and increase in emotions such as anxiety or depression (Hallowell & Ratey, 2011). It is also important to monitor growth—both height and weight. Any family history of heart problems should be considered prior to introducing medication. As with any medication, careful monitoring is required but medication has been proven to be an effective treatment regimen for individuals with ADHD (N. Weder, personal communication, 2017).

Therapy can also be useful if the therapist is willing to perceive the strengths of the child. Therapeutic treatment must be used to support, not to diminish the child's self-esteem. Parents are often the best sources of information regarding their children, but parents should also be willing to be an active, flexible participant in therapy either directly or indirectly. The child is

more likely to be successful in therapy—at any age—if they feel understood and appreciated. Because the symptoms of the ADHD can change over time, assigning the right therapy at the right time is important. Psychotherapy can be useful in treating anxiety issues while group therapy can address social issues. Evidence-based therapy such as cognitive behavioral therapy can be useful in behavior modification, particularly in cases of impulsivity. It is important for the parent to be mindful and to stay current with scientific studies and treatments that will offer the most benefit to their child.

Oftentimes, a developmental disorder can restrict a person's ability to consider their mental states and the mental states of others. This can certainly be true in the case of an ADHD diagnosis where the cornerstones of symptomology include inattention, hyperactivity, and impulsive behavior. With impulsivity and hyperactivity as cornerstones of symptomology, behavior management is often difficult for children with ADHD; they often lack the ability to stop and assess a situation. This can often lead to misinterpretations of behavior; what a parent or adult may see as intentional, negative behavior is simply the result of a lack of impulse control or inhibition.

2. ADHD and Families: 3 Case Studies

Alice and Jack: Siblings with ADHD

The following three case studies illustrate ways in which ADHD present and how families are frequently affected. The symptoms of ADHD can present differently even within the same family. To illustrate this, we look at the diagnosis of Alice and her brother, Jack.

Alice

Alice is an energetic, creative, sensitive, and loving elementary-aged girl. She is very kind and social, welcoming and nurturing. She is upbeat, playful and charismatic and has an incandescent smile. She is also very driven and independent when involved in tasks she finds motivating. She devotes a lot of energy to making connections with classmates and peers; when a connection is made, she is a vivacious and loyal friend. And she adores her big brother, Jack.

Alice was a typical baby; she was happy and socially engaged and she achieved her speech and motor milestones within appropriate time frames, sometimes early. Toilet training was a big challenge and her mother often blamed herself for pushing her to comply before she was ready because of preschool requirements. Ultimately, Alice did not acquiesce and she and her parents remained on a potty-training-emotional-rollercoaster for too long. As a toddler, she was very active, but she also displayed sensory sensitivities to textures and sounds. Sleep has been difficult for her at times, but her parents remain steadfast to a healthy sleep schedule so she only occasionally experiences nightmares. Her hearing and vision are normal. She is petite, but has a healthy appetite for pasta and bread.

School environments have been very challenging for Alice since the age of two. Beginning at age two, she attended a Montessori school until she was almost four-years-old. At the Montessori, she was non-compliant with the teachers, sometimes experienced conflict with

peers, and she often hid under the tables when she felt stressed. After a period of time, it became clear to her parents that she was being shamed and bullied by the teachers which left Alice and the family traumatized. The situation with the Montessori school resulted in Alice being nervous about any school environment; her parents were hesitant to have her re-enter any early education setting. However, they witnessed her creativity and desire to make friends, something a home environment alone could not sustain. Thankfully, Alice enrolled in a progressive, early childhood education program and remained there for two years. The teachers were patient and supportive; they provided redirection and extra assistance with transitions. The school was a perfect fit for her creative talent and curious nature. During this time, Alice's teachers expressed concerns about her speech and sensory issues and they suggested a speech and occupational therapy evaluation with therapies began shortly thereafter.

At age 6, Alice began kindergarten at a local public school. Her classroom consisted of 17 children, one teacher, and two aides. Initially the new school was a difficult transition and Alice displayed impulsive behavior and non-compliance. During teacher conferences, it has been mentioned that when Alice is engaged or confident in her abilities, she will work diligently on a task. However, there have been times when Alice swings from emotional highs and lows quickly. At the beginning of the year, she would defy teacher requests and if reprimanded she might react inappropriately by further exaggerating the behavior she was asked to stop. She also displayed impulsive physical behavior with her peers.

Because of Alice's long history of difficulties with sensory processing, language, and behavioral and emotional dysregulation, a neuropsychological evaluation was conducted when she was 6. There were many concerns about behavior, but her parents were primarily concerned about learning disabilities. She would often be overstimulated in busy or loud situations, had

trouble finding the language to convey her thoughts, and she reacted physically when frustrated or experiencing an excess of emotion. Interactions with her parents were very uneven. She would often be compliant with her mother, but noncompliant with her father or brother. She would experience intense outbursts that involved yelling, screaming, hitting and kicking. She also had trouble taking responsibility for her actions and would often stare blankly when confronted about her behavior. She also struggled with transitions and would get overstimulated when presented with too many choices or options. Alice seemed to lack a language filter and would often make inappropriate comments to adults and children. However, she would often correct herself or apologize if she realized that she had hurt someone's feelings. Although very energetic, sports and other extracurricular activities were also challenging for Alice.

With all the aspects of Alice's impulsive behavior, academic and social struggles, and inattentiveness, her parents understood that this was not intentional, but were at a loss regarding providing the best environment and care. It felt very much like she was struggling with the behavior, not that the behavior defined her character. Initially, her parents waited to see what age and experience would bring to young Alice, but ultimately realized what a difficult situation it was for her and for the family as a whole.

Ultimately, the neuropsychological evaluation revealed that Alice presented with vulnerabilities in several areas. The neuropsychologist's findings revealed a diagnosis of Language Disorder (DSM-5 315.39; ICD-10 F80.2), a diagnosis of Attention Deficit Hyperactivity Disorder with predominantly impulsive features (DSM-5 314.01; ICD-10 F90.1), and a Developmental Coordination Disorder diagnosis (DSM-5 315.4; ICD-10 F82). Academically, Alice's various difficulties placed her at very high risk for the emergence of learning disorders characterized by weaknesses in language processing, phonological awareness,

attention modulation, and recall/retrieval which greatly interfered with her early literacy and math skills. Reading and writing were particularly difficult and the clinician placed increased attention to support in these areas. From a social-emotional perspective, Alice's linguistic and cognitive challenges were thought to affect her self-regulation and peer interactions. Social and academic demands placed her at an increased risk for experiencing issues with self-esteem, anxiety, and mood.

Given the complexity and frequency of her struggles, several recommendations were suggested. To address her abundant, complex academic impairments, an Individual Education Plan (IEP) was established with her public school. She now receives consistent, dedicated support in school including a 1:1 aide, regular speech and language therapy, and daily support from a special education teacher. In addition, Alice was prescribed a low dose of stimulant medication to improve her symptoms of distractibility and impulsive behavior. Shortly after the diagnosis, it was recommended that Alice and her parents begin an evidence-based, daily therapeutic plan (PCIT) to target non-compliance and behavioral inconsistencies.

PCIT is an evidence-based treatment for children with behavioral problems. The duration of treatment is typically from 12-20 weeks, depending on progress. Sessions take place with a therapist once a week with homework or special play time between the parents and child daily. During sessions with the therapist, the parent is given an earpiece. The therapist is able to see interactions between the parent and child through a one-way mirror. The therapist observes these interactions and will coach or guide the parents—via the earpiece—in real time during the session (What is Parent-Child Interactive Therapy?, n.d).

There are essentially two phases. The first phase is child-directed and desired outcomes include: reduction of tantrums or negative attention-seeking behaviors, better attachment

between parent and child, increased pro-social behavior, and increased self-esteem in the child. Targets of the more parent-directed second phase include: decreased defiance, compliance with requests from parents, improved public behavior, and increased parental calmness and confidence during discipline (What is Parent-Child Interactive Therapy?, n.d.). Graduation from the program occurs when parents are able to master assigned sets of skills from both phases and rate their child's behavior within normal limits.

Alice's parents were hopeful that this would help Alice to regulate her behavior, particularly at school or in social settings. Additionally, Alice and her father also had somewhat of a contentious relationship, particularly at night when she was asked to get ready for bed. Alice and her parents attended weekly sessions and were very dedicated to adhering to the assigned homework and special playtime at home. During playtime, particular phrases are supposed to be used to let the child know that the parent is paying attention. For instance, if the child is putting blocks together in a particular way it can be pointed out that the parent sees the child is doing this task: "I see you putting the 2 blocks together." Parents are also discouraged from asking the child questions about what they are doing. For example, a parent should refrain from saying: "What are you building?" During the first phase, the child directs the play and the parent is responsive. In the second phase, the parent directs the play and the child is asked to comply. When a command is given, the parent vocalizes and points to the targeted object which should make it clear for the child to comprehend. Additionally, the child is only given a certain amount of time to comply. The child is supposed to react "quick like a bunny" to the command. If the child complies, the parent gives labeled praise such as: "Thank you for handing me the doll's clothes." If the child does not comply, the consequence can include being put in a time-out chair or specified area of the playroom for a short period of time.

During one particular session with Alice and her parents during the second, parent-directed phase, a request was made by Alice's mother for Alice to hand her a particular block to add to a building. Alice's mother vocalized and pointed to the object. Alice did not immediately comply to the request. As a result, the therapist instructed Alice's mother to escort Alice to the time-out chair because she was non-compliant. However, in this moment her mother refused to ask Alice to sit in the time-out chair because she understood something about her child that perhaps the therapist could not: Alice was having trouble understanding the command. Again, Alice's diagnosis includes weaknesses in language processing, phonological awareness, attention modulation, and recall/retrieval. In essence, there are times when Alice does not act quickly. It is not because she is being defiant as the therapist assumed—but because she could not understand or process the language quickly. Her mother could see in Alice's eyes that Alice wanted to comply and was trying to understand but for the therapist, she just wasn't quick enough.

Shortly after this session, Alice's mother began to distrust the validity of aspects of PCIT. Alice graduated from the program and although there were aspects of her behavior that improved, the process of this particular treatment felt robotic and disconnected. Mastery of skills was typically a memorization of phrases, a script, for the parent to incorporate in play with the child, but real listening and connection was often sacrificed to ensure the right things were said. In the case of Alice, this modality did not ensure that she was seen and understood. Alice's mom looked for better ways to connect with her child knowing that Alice's behavior could be improved through being seen. Difficulties with behavior and increased parenting stress had affected the attachment relationship; perhaps the best course of treatment was to find ways to improve attachment bonds.

Jack

Jack is a very sweet, empathetic, highly intelligent, curious middle-schooler. He is socially outgoing and connects especially well with adults. Outside of school, he enjoys seeing friends for playdates, playing sports, and dedicating himself to Tae Kwon Do. He is gifted at technology and math and enjoys helping others with his ability. In his family, he is the tech consultant. His hearing and vision are normal. He sleeps well and has a good appetite. Jack strives to be successful in school and to make his parents and teachers proud of him.

Initial concerns regarding Jack included his focus, executive functioning, and self-confidence. Sensitive by nature, Jack tends to experience life disappointments in a more profound way than other people. Jack cares deeply about and is very connected to his family; disruptions weigh on him emotionally. He can be hyperactive and easily distracted. Both in home and at school, he struggles with remembering things in the short term and sitting still in his seat. Academically, Jack has a history of difficulties with reading and writing, particularly in organizing and initiating tasks.

Jack experiences high levels of emotional lability. He is overly critical of himself and becomes very dysregulated (cries) over relatively minor things. He is driven to please and worries about making mistakes or not being successful at a task. Jack has been known to experience separation anxiety; when he was younger, there were instances where he would get upset if he did not immediately see a caregiver picking him up from school. Jack also likes to know the plan and routine ahead of time and responds well to warnings for unexpected transitions. Socially, Jack has a close group of friends and generally gets along well with others. However, he can sometimes be persistent in his desire to connect and might not recognize or respond to another child's nonverbal cues that they are not interested. He typically avoids

confrontation, although he is getting better with asserting himself and his needs. There have also been concerns about Jack's maturity and how this can affect his peer interactions.

Regarding educational history, at age three, Jack attended part-time preschool at a local church where he experienced separation anxiety during drop-off; he was otherwise regarded by his teachers as a social, kind, well-behaved, and engaging youngster. He attended a magnet program at the local public school for pre-K through the 1st grade. There were no concerns raised during that time about Jack's attention or activity levels, although he had some trouble learning to read. In August 2015, he and his family moved into a new house and Jack transitioned to the local public school for 2nd grade. This new school was more academically rigorous and during this year, his teachers expressed concerns about his focus and his ability to work independently. In 3rd grade, Jack continued to experience difficulties in these areas, as well as with reading comprehension, and a tutor was hired to work with him outside of school. Jack currently attends middle school. While his parents anticipated a challenging transition, he has acclimated pretty well.

Jack's teachers have described him as an extremely sweet and social child who gets along with the other kids in his class and usually seems to be in good spirits. However, he has trouble remaining focused, resisting distraction, and working independently without adult support and redirection. Regarding his academics, Jack has difficulty discerning detail from what he reads as well as identifying the bigger picture or main message. He also needs support with brainstorming and organizing his thoughts for written assignments. Jack displays good conceptual math skills, although his attentional issues can interfere with the quality of his work.

According to the neuropsychologist who evaluated Jack, Jack is a bright and hardworking boy who possesses tremendous scatter and inconsistency in his neuropsychological profile.

Foremost, Jack's visual-spatial and hands-on visual-constructional abilities are extraordinary, as he scored in the 99th percentile on WISC-V visual-spatial index. His visual problem-solving skills are also well-developed, and he scored at or above expectations on most tests of fundamental language, including verbal reasoning, vocabulary knowledge, phonological awareness, higher-order language, and comprehension of spoken language. While difficult to directly assess or quantify, Jack also displayed an outstanding work ethic and a willingness to persevere in the face of challenge, especially when he was feeling confident in himself. Collectively, the evaluation's findings suggest an outstanding potential to learn and acquire new skills, provided Jack's weaker cognitive and linguistic areas are appropriately supported or accommodated for.

The neuropsychologist's findings also identified vulnerabilities in aspects of expressive language which qualify Jack for a Language Disorder diagnosis (DSM-5 315.39; ICD-10 F80.2). Jack performed below expectations on several standardized tests of attention, which define a diagnosis of Attention Deficit Hyperactivity Disorder with predominantly inattentive features (DSM-5 314.00; ICD-10 F90.0). The testing results also revealed vulnerabilities in aspects of executive functioning. Jack's handwriting mechanics are weak, which combined with findings of impaired graphomotor precision, qualify him for a diagnosis of a Developmental Coordination Disorder (DSM-5 315.4; ICD-10 F82). Most concerning, however, are Jack's problems with more complex written expression, as he has trouble with organizing his writing, expanding on his ideas, and editing his work. Collectively, Jack's vulnerabilities in handwriting mechanics, sentence structure, and putting his thoughts on paper in a coherent, sequential, and organized fashion, are consistent with a diagnosis of a Specific Learning Disorder with impairment in written expression, otherwise known as dysgraphia (DSM-5 315.2; ICD-10 F81.81). Finally,

Jack performed within expectations on tests of applied/conceptual math problem-solving and numerical operations, although his math fact automaticity is highly inconsistent, which is also likely connected to his retrieval challenges. These learning problems, if not addressed, will make further learning for Jack even more difficult, especially as the demands increase as he advances in school. The neuropsychologist emphasized that it is important for Jack to receive intensive remediation and support in order to improve his skills and maximize his opportunities for academic success.

Tommy: A Case from the Literature

In a chapter titled “The Big Struggle,” Hallowell and Ratey (2011) discuss family dynamics and ADHD. A case is given of the Eldridge family and their high school son, Tommy. In this particular scenario, Tommy’s mother chides him for not completing his homework which are resulting in bad grades. Mrs. Eldridge assumes Tommy does not care about his grades and that he just wants to get out of the house to do things he enjoys, so she punishes him by saying he won’t be leaving the house that weekend. This battle escalates to verbal insults and physical altercations and eventually Tommy is told to leave the house and not return. Tommy is later brought back home by police after he was found in a bus station at 3 am. After Tommy returns home, the three of them sit down to talk and his dad suggests they come up with a plan; but first his mother wants an apology.

Tommy states: “I’m sorry. I didn’t mean for you to fall down. I didn’t mean to call you what I called you.

“Then why did you say it?” she questions.

Tommy answers: “I don’t know. I was mad. It just came out.”

His mother responds” But that’s the whole problem, Tommy. You don’t mean to do the things you do do, and you don’t do the things you say you mean to do.”

“So, what should I do?” Tommy asks. “Commit suicide?”

His mother vents: “You should try to get your act together. You should take advantage of all the help we’ve tried to give you. You should show up for your tutor. You should make the effort to bring home your assignment book so we can help you check it over. You should consider telling the truth when we ask you if you have any tests on Friday. You should take the chip off your shoulder and get over thinking the whole world is against you or just doesn’t understand you. You should show us a little respect. You should-“ (160)

Tommy’s Dad interrupts: “Tommy, you’re not even listening to your mother, are you?”

Tommy responds: “I’m listening, Dad. I could recite it all back if you want. I’ve heard it all before.”

Dad angrily responds: “Then why don’t you do something about it?”

Tommy simply states: “I don’t know.”

Tommy’s dad retorts: “What do you mean you don’t know? I can accept anything but that. That’s just your way of tuning us out. You don’t know. Well, why don’t you know? Can’t you think about it and come up with some explanation as to why you’re such a screw-up? Are you just stupid? I don’t think you’re stupid although I’m beginning to wonder. You just won’t wise up, will you?

Tommy’s mother considers: “I wish I could give up on you. I wish I could just let you fall and not give it a second thought.”

“So do I,” answers Tommy.

These case studies illustrate how important it is to understand the mental states that may underlie a person's behavior. In the case of neurodiversity in particular, it is important to consider that the way one person's processes an issue and responds will be different than another person. It is important to consider that each person is a specific entity with their own thoughts, feelings, and emotions. Too often, scenes such as the example of Tommy play out in ADHD families. It is difficult to understand the lack of focus or motivation in the child. Parents may consider: "Why can't my child do what I ask?" or they often compare their child to other children who are able to be independent. What is difficult for parents to understand is that the child is not willingly being defiant. The child is not a problem child, but may have difficulty with executive functioning, working memory, focus, and impulse control. And while a parent may think they have faced similar challenges, for a person with ADHD tasks can be difficult to manage and a parent may not understand if the parent is neurotypical. Hallowell and Ratey (2011) posit that when a child is seen as defiant, parents tend to become more controlling setting stringent limits which can make the child feel more alienated and the parents become more exasperated. Parents can see this as a behavioral problem, not a neurological effect.

It is important to understand that ADHD is a diagnosis, but the behavior should not define the person. A person with ADHD may tend to be reactive, unable to naturally respond to events in a calm, mature manner. This often leads peer rejection and social hostility. As with the executive functioning component, the child begins to think that they have a personality flaw, that they are a bad person, and that they are unable to control themselves. Additionally, children with ADHD often have feelings of guilt and low self-worth because they are not able to organize themselves (executive functioning deficit) or their impulsive behavior is often misinterpreted. The need for a child with ADHD to be seen and understood, especially by the caregiver or

primary attachment figure, is paramount. The child needs a parent to be understanding and curious about the child, not controlling and frustrated. Hostility can make the child feel unsafe and hypervigilant to threats which can impede development and cognition. As Hallowell and Ratey state: “The children [with ADHD] who do best are the children who have positive human connections in their lives” (Hallowell and Ratey, 2011, p. xvii). This is what makes the need for mentalizing or reflective functioning so important for families with ADHD.

3. Mentalizing and Attachment-Based Approaches

Mentalizing

Parenting can be challenging in both neurotypical and neurodiverse families. ADHD can cause emotional dysregulation not only for the child, but for the parent as well because what can be perceived as intentional, negative behavior from the child can actually be facets of the disorder. So, the best course of treatment for the child with ADHD begins with the parent and the parent's capacity to mentalize. British psychoanalyst Peter Fonagy and colleagues pioneered attachment and parent-child dyads by applying the concept of mentalizing. Fonagy & Target (1998) introduce mentalizing as a capacity to understand one's own mental states—intentions, feelings, thoughts, desires, and beliefs—to make sense of and to anticipate another person's actions. The ability to assign meaning to internal states is critical to intrapersonal functions because it unveils the subjective self. Acknowledging the internal, personal experience is crucial to developing a framework for self and affect regulation (Slade, 2005). The parent must be able to interpret and acknowledge their own mental states in order to understand and interpret the mental states that underlie behavior in the child. In this next section, I will discuss therapeutic applications of reflective functioning and how this is paramount to facilitating secure attachment.

The concept of mentalization is entrenched in several disciplines including cognitive psychology, attachment theory, and psychoanalytic theory (Etezady and Davis, 2012). In this sense, it can be envisioned as: “the capacity to think about feeling and to feel about thinking” (M. Target as cited in Slade, 2005, p.271). While the terms mentalization and reflective function are often used interchangeably by clinicians and researchers, reflective function is an “overt manifestation, in narrative, of an individual's mentalizing capacity” (Slade, 2005, p. 269). Reflective thinking involves linking behavior with states of mind, the parent's frame of mind

with the child's behavior, the child's behavior with the parent's behavior, stressors in the home with the child's behavior, and the parent's own childhood with the way she or he reacts to the child (Etezady and Davis, 2012, p.48).

A parent's ability to reflect on their own mental states and to consider the mental states of their child creates a more sensitive parenting dynamic and instills in the child the sense of security that is needed for optimal development. "The centrality of the parent as mediator, reflector, interpreter, and moderator of the child's mind cannot be overemphasized" (Slade, 2005, p. 273). Being available to a child experiencing dysregulation can help the child to feel protected and secure in an overwhelming moment. In the 1990s, Fonagy and colleagues conducted a study known as the "London Parent-Child Project," (Fonagy et al., 1991). This study explored whether a parent's ability to view their child as a separate entity with unique mental experiences—and to accommodate the mental states of the child—was fundamental to parenting and secure attachment bonds. To understand and to stay curious about the mental states of the child may help the parents to better interpret and to understand the underlying behavior of the child. However, in order to effectively mentalize about another, one must first be able to recognize one's own mental states.

Non-reflective caregiving can profoundly impact a child's development. Fonagy states: "In the case of chronically insensitive or misattuned caregiving, a fault is created in the construction of the self, whereby the infant is forced to internalize the representation of the object's state of mind as a core part of himself" (Fonagy et al., 2002). The child becomes susceptible to the—sometimes negative—mental states of the parents. The parent is not able to view the child as a separate entity with their own thoughts and feelings. Unfortunately, in some cases, "The infant then takes on the parent's hatred and aggression, a primitive form of

identification with the aggressor” (Slade, 2005, p. 273). Survival for the infant, both physically and emotionally, depends on the parent. When the parent is not attuned to the needs and experiences of the child, attachment bonds are compromised. The infant adapts to the moods of the parent. In cases of unsettling abuse and trauma, adapting to the parent’s mental state may be too terrifying or overwhelming for the child and “sharing his mind with the caregiver becomes dangerous, rather than a rich-opportunity for self-knowledge and emotional containment” (Slade, 2005, 273).

It is important to consider how understanding behavior often affects the attitude of the parent toward the child. Fonagy (Simms/Mann Institute, 2016) uses the example of a child covered in chocolate cake, made by the parent, at the child’s first birthday. How will the parent react? Either the parent views this situation as the child experimenting and having fun and plays along in a jovial interaction or the parent sees the child as trying to compromise their hard work which can cause the parent to feel frustrated. The reaction of the parent is critical in establishing the rules of behavior between parent and child. The child is trying to understand the meaning of their interactions in the actions of the parent. If the parent reacts negatively, this can send a signal to the child that spontaneity is met with disapproval; a positive reaction tells the child that this type of exploration is supported by the parent. It can often be difficult for parents to see the child as the child is. Oftentimes, the parents can assume or misinterpret the intentions of the child which makes it important for the parent to remain curious and open minded as to what drives the child’s behavior. When mentalizing breaks down, an individual can experience high levels of frustration and is susceptible to emotional responses. In this heightened state of emotion, an individual is much less able to take in another person’s perspective.

Reflective functioning involves the child feeling secure because they are known; they are known because they are seen by a responsive caregiver who is able to meet the child's needs and provide stability. When a child feels enveloped by this sense of security, they know they are able to trust the caregiver and to explore the world knowing there is a safe and secure environment that will welcome them upon return. Without trust and the stability of these initial experiences with a sensitive and reliable caregiver, a child may view the world as a threat instead of as an opportunity.

Child development theories can illustrate a child's first interactions with caregivers and other members of family and society. We now look at the theories behind reflective functioning to further illustrate the importance of caregiver sensitivity in order to facilitate optimal development for the child.

Mirroring

One facet of mentalization theory is containment. Containment describes the ability for the parent to reflect the internal state of the child, but to depict it as a manageable experience (Etezady and Davis, 2012). Fonagy has stated that secure attachment is the direct outcome of successful containment (Fonagy, 1996). In this exchange, the parent communicates to the child that the child's feelings are understood and expressed in a way that the child can have a similar experience or mastery (Fonagy & Target, 1997; Fonagy 1996). This is known as contingent marked mirroring. Contingent marked mirroring involves the caregiver being responsive to the internal state of the child while adding an element which highlights that the child's mental state does not directly correspond to the caregiver's mental state (Fonagy, Gergely, Jurist, & Target, 2002). The caregiver represents the child's mental state into a symbolic model of that state (Etezady and Davis, 2012). The parent conveys to the child that they understand what the child is

feeling, but the parent re-presents it slightly differently for the child. In this portrayal, the caregiver may raise or lower their voice or use hand gestures to mirror the child's gestures, facial expression, or words. The parent captures the child's affect but does it in a way that is slightly different. The child's experience is delivered back to them by the caregiver in a meaningful way that allows the child to have a better understanding of the experience because it is presented more dynamically by their most trusted source. For example: during mealtime, a child who is hungry may become cranky or distressed. The parent is available to capture the child's state perhaps by saying, "Oh no, you're upset. Perhaps you are hungry? Let's get you some food to see if that helps you to feel better." In the tone and response of the response of the parent—which should not be an exact match to the child's state but still convey the general emotion—the child can feel seen and validated because the parent is open and curious to the experience of the child. The emotional and cognitive mind of the parent supports the self-organization of the child.

There are also failures of affect mirroring that can occur early in a child's life. If the "mirroring" or response of the mother is too close to the child's mental state, it can agitate rather than contain arousal in the child. The mother's delivery of acknowledging and reframing the child's experience is crucial because she presents the experience as symbolic. If the caregiver responds with fear to a child's fear, this does not comfort the child. It only arouses his affect. In another example of affect mirroring disturbance, the parent may acknowledge the child's distress, but the parent is inappropriately responsive. A child may cry but the mother, viewing the cries as manipulation, may choose to ignore them. (Slade, 2005). The mother is not able to create an accurate symbolic representation of the mental state for the baby and so "this secondary representation created will be distorted . . . The self will feel empty because . . . secondary representations of affect lack the corresponding connections within the constitutional self" (as

cited in Slade, 2005, p. 273). Winnicott defines this as the false self as: “an adaptation to the affects and minds of the other that leaves the self feeling empty and unreal, and the internalized other alien and disconnected from true self experience” (Slade, 2005, p. 273). Development can become fractured and the child struggles with developing relationships and trust in others because the relationship with the primary caregiver is uncertain or absent.

Winnicott and Object Relations Theory

Marked mirroring can be closely identified with psychoanalyst Donald Winnicott’s theories of child development. Winnicott’s early work includes the definition of the holding environment. The holding environment is a safe space in which children are able to create and to become their authentic selves because they are able to trust in the stability of a caregiver. Winnicott uses the description of the “good-enough mother” to define the relationship between mother and child in which the child’s requests and needs are sufficiently met. According to Winnicott, it is essential that the mother adapts to the needs of the infant; her devotion is essential to human development. Without the mother, healthy human development is difficult to attain (Winnicott, 1953).

Having the recognition of another fosters the baby’s own creative capacity. The responsiveness of the mother or other is essential. When there is a breakdown in the process of this intersubjective state, Winnicott states that the baby’s own creative capacity begins to atrophy, and in some way or other they look around for other ways of getting something of themselves back from their environment (Winnicott, 1967). Healthy intersubjective development relies on this critical early communication, recognition, and mutual understanding of intentions. The baby begins to decipher and internalize essential elements of social interactions with the mother such as mood. If the mother is in a bad mood, the baby perceives this and if the mood

becomes pervasive, the baby may begin to withdraw. The baby begins to understand the mother and other members of the family as a mirror in which the baby's self is reflected. The child begins to structure their idea of others and socialization based on these initial experiences. The attitude of the mother and the members of the family present the child with enrichment opportunities through healthy, supportive, loving interactions.

Winnicott's theories are closely aligned to his contemporary, John Bowlby. Regarding the "initiation of mother-infant interaction," Bowlby states:

Whereas an infant's initiation and withdrawal from interaction tend to follow his own autonomous rhythm, a sensitive mother regulates her behavior so that it meshes with his. In addition she modifies the form her behavior takes to suit him: her voice is gentle but higher pitched than usual, her movements slowed, and each next action adjusted in form and timing according to how her baby is performing. Thus she lets him call the tune and by a skilful interweaving of her own responses with his creates a dialogue. (Bowlby, 1988, p.7)

Through John Bowlby's and Donald Winnicott's theories of attachment and object relations, we begin to understand the importance and of social interactions in early child development. They both place significance on the role of the mother in infancy and early development to instill a secure sense of being. Whether children are able to follow innate signals from an early age to form attachments or whether an infant transitions from a state of being one with the mother to being something other than the mother, these remain integral aspects to healthy human growth and development. Because of pioneers like Bowlby and Winnicott, we have a vivid understanding of the importance of early social relations which has become a cornerstone for modern-day developmental psychology.

Attachment Theory

In order to understand the importance of mentalizing, it is important to have a comprehensive understanding of attachment theory. John Bowlby's concept of attachment theory emerges by challenging and expanding on previous psychoanalytic thinking to analyze the dynamics between infants and caregivers (primarily mothers) and how failure for the infant to form a secure attachment can have lasting effects on an individual. Attachment has an internal motivation and is an innate part of human nature often triggered by a specific environmental stimulus. Attachment behavior is observed when a person senses fear, fatigue, or illness and seeks proximity to a source that is better equipped to deal with external forces of the world during an early critical period. This adaptive role—first observed in baby goslings—provided Bowlby with insight on patterns he observed when children would become separated from their parents, specially mothers (as cited in Crain, 2005). A child perceives abandonment—when they are not in proximity to a primary caregiver—as a risk to their survival value and responds with attachment behaviors.

Bowlby begins his career as a psychoanalyst adhering to the traditional principles created by Sigmund Freud. Freud is the first person to delve into early experiences and how these experiences affect the psyche, something that becomes a great purpose of study for Bowlby. Bowlby echoes the Freudian Oedipal conflict to illuminate the tension between love and hate. Ambivalence is within all of us; it is the regulation of this conflict that humans struggle with, even at an early age.

In post-war Europe, Bowlby's (1951) *Maternal Care and Mental Health* is published detailing the effects on personality development in the absence of consistent maternal care in early childhood. He studies the consequences of children being separated from their families

during the war. In some cases, parents chose to relocate their children from the epicenter of the war. These children were often sent to relatives or friends outside of the city. However, separation from the family created distress in these children because of the absence of familial bonds. Bowlby begins to alter his psychoanalytic view to stress that attachment is primary, not secondary as purist psychoanalysts believed. Bowlby understands that the children's connection to the primary caregiver is about more than food. The caregiver is not just food source, but a source that provides the child with security and protection against threats in the world.

A divergent viewpoint can often be met with skepticism. Here, we begin to see a paradigm shift in Bowlby's theoretical framework and with it brings controversy. Without substantial evidence to prove that these types of experiences with separation have substantial effects on personality development, he is discounted by psychoanalysts and other mental health professionals. He maintains that real life events cannot be excluded in opposition to the psychoanalytic belief that the role of fantasy is more integral to the development of the psyche. Also at this time, important developments begin to surface to support his theory.

In 1951, Bowlby is introduced to ethological findings by Konrad Lorenz. Purely by accident, Lorenz discovers how the Greylag goslings he is raising begin to imprint on him, assuming that he is their mother. These goslings were forming strong bonds without the need for food being a requirement. The goslings begin to follow Lorenz during a critical time in their development when their innate instinct to follow their mother is triggered by an environmental stimulus (Lorenz). Persuaded by Lorenz's cross species comparison, Bowlby finally encounters evidence to give merit to his theory. His data are primarily gathered through observations as opposed to experimental methods (traditional psychoanalytic modes of free association or play

would not have been relevant to animal studies). He begins to define attachment as its own class of behavior with distinct dynamics, non-dependent on a psychoanalytic view of food or sex.

Attachment has an internal motivation and is an innate part of human nature often triggered by a specific environmental stimulus. Though it wasn't clear what a critical window of attachment might look like in humans, it was the early attachment experience that was essential to healthy human development. Bowlby found a close correlation in what ethologists define as imprinting, when a specific stimulus releases an innate instinct during a critical early period. Bowlby sees through ethological observations that in this critical period the species chooses a specific target to imprint upon and that after this period, it no longer responds to those adult figures.

The application of ethology seems to clarify what has baffled psychoanalysts on what constitutes separation anxiety. Bowlby traces the origins of trauma prospectively as opposed to standard modes of tracing an advanced clinical syndrome retrospectively. He concludes that it is the increased risk—not simply an obvious high risk—that causes animals, and humans, to respond with fear in certain situations. Fear manifests when there is a marked change in a situation because it has survival value. We can see a child perceives abandonment as a risk to their survival value and reacts with attachment behaviors.

Bowlby proposes 4 phases of attachment: phase 1 (birth to 3 months) indiscriminate responsiveness to humans, phase 2 (3 to 6 months) focusing on familiar people, phase 3 (6 months to 3 years) intense attachment and active proximity-seeking, and phase 4 (3 years to the end of childhood) partnership behavior. While each phase carries its own value, within the first year of life, children begin to develop a clear pattern of the attachment figure's responsiveness to the child's needs. The attachment figure should create a safe haven in which the child can

explore and feel protected from situations that inspire fear. They are assured that their needs are satisfied and that they have someone to count on when they need them.

To better understand degrees of attachment, we can turn to Bowlby's colleague, Mary Ainsworth. Ainsworth arrived in London in 1950 (Crain, 2011, p. 59) and was impressed by the work of James Robertson (Ainsworth, 1991) and his observations of infants (or children under 3) being separated from their mother. His observations yielded 3 categories (Crain, 2011, pp. 57-58): protest, despair, and detachment. During protest, the child screams, cries, and searches for the mother, hypervigilant to any sound or sense of her. The child will typically not accept any form of substitute care during this phase (Crain, 2011, p. 57). In despair, the child may become less active, almost as if in mourning. Although they may feel hopeless, the child continues to search for the mother (Crain, 2011, p. 58). The final stage of Robertson's observation is detachment. Here, the child accepts care from caregivers other than the mother and appears happy. However, upon the mother's return the child does not engage with her, almost as if he does not know her. This may be a protective mechanism against further disappointment and perceived abandonment (Crain, 2011, p. 58). It was Ainsworth's work with Robertson that led her to realize that she would conduct short-term longitudinal study of infants in the first year of life based on Robertson's methods (Ainsworth, 1991). Perhaps what was most productive and distinguishes Ainsworth's work from Robertson's is that she was able to define patterns of attachment based on what a child did when the mother was away and then returned. What happened upon the reunion of parent-child was a telling illustration on what type of attachment pattern was present.

During the 1960's, Ainsworth conducted studies between mothers and infants first within the home and then at a playroom at Johns Hopkins University in Baltimore. Ainsworth created

an important observational research method, the Strange Situation. The Strange Situation is a 20-minute procedure which assesses a child's attachment behavior. The observer is interested in the child's reaction during the mother's absence, but also what happens when the mother returns.

The mother is asked to leave the room and the child is either left with a stranger (often a graduate student) or alone. The observer studies how a child uses the mother or caregiver as a secure base and what results when the mother leaves the room. Bowlby defines a secure base as a provision provided by the parents from which the child explores the outside world and to which the child returns to knowing it is a welcome, secure environment where he is comforted, reassured, and nourished. This role necessitates the availability of the parent, ready to respond and encourage, and intervene--but only when necessary (Bowlby, 1988, p. 11). During the Strange Situation, the notion of the secure base is tested and from observations, Ainsworth was able to decipher patterns of attachment in the parent-child dyad.

Upon the mother's return, the reunion between mother and child reveals much about the attachment which Ainsworth organized into three categories: securely attached, insecure-avoidant, and insecure-ambivalent. Most infants displayed securely attached patterns. Securely attached infants use the mother as a secure base to explore and when the mother leaves the room, the infant becomes visibly upset. However, once reunited with the mother, the infant is happy and eager to explore once again. This defines a healthy attachment style in which the mother is responsive and the infant trusts the mother as a protector.

Insecure-avoidant infants constituted about 20% of the tested population. These infants explored without using the mother as a secure base, did not seem upset when the mother left the room, and did not seek her attention when she returned. It was determined that the behavior of these mothers was primarily insensitive or rejecting in interactions with the infant.

Insecure-ambivalent infants were very preoccupied with their mothers becoming clingy and refusing to explore. These infants become extremely upset when the mother left the room and were ambivalent toward her when she returned. The caregiving pattern of these mothers was typically inconsistent, warm and responsive at times, but not consistently attentive. This pattern was seen in about 10%-15% of the children studied (as cited in Crain, 2005). Attachment patterns developed in childhood can often have lasting effects throughout a person's life.

Mentalizing-Focused Treatment

In every nursery there are ghosts. There are the visitors from the unremembered pasts of the parents; the uninvited guests at the christening ... Even among families where the loved ones are stable and strong the intruders from the parental past may break through the magic circle in an unguarded moment, and a parent and his child may find themselves reenacting a moment or a scene from another time with another set of characters ...

Another group of families appear to be possessed by their ghosts. The intruders from their past have taken up residence in their nursery claiming tradition and rights of ownership. They have been present at the christening for two or more generations. While none has issued an invitation the ghosts take up residence and conduct the rehearsal of the family tragedy from a tattered script (Fraiberg et al., 1975, pp. 387-388, as cited in Fonagy et al., 1993, pp. 958-959).

Before a child is ever born, a parent may conjure vivid images of what they hope their child to be. The birth of a child can be powerfully transformative for the parent. The role of the parent is often defined in some way by the way the parent themselves was raised. There may be things that a parent believes were done well in their childhood and other things that they would change if given the opportunity. The birth of a child can be a way for a new parent to start anew,

to correct any mistakes of the past. However, it is often difficult to abolish behaviors that are engrained in our being. And so, if careful consideration is not paid, a parent can be at the mercy of past indiscretions, bound to repeat behaviors they seek to change. A bond between a parent and a child can be powerful, but it requires the unveiling of truths and acknowledging past joy and pain. When a parent accepts the truth of themselves, they are able to see the true nature of the child.

In the London Parent-Child Project (Fonagy et al., 1993), Fonagy and colleagues conducted research to investigate attachment and how a parent's conflicted past can influence present interactions with their child; moreover "that the that the quality of the mental representation of the object and the representation of the self's relationship to it may be a further important determinant" (Fonagy et al., 1993). In order to study mental representations and patterns of attachment in parents, they employed a measure which studies adult attachment patterns known as Adult Attachment Interview (AAI). The AAI was created to assess attachment patterns between infants and caregivers (Ravitz et al., 2010). The AAI identifies 4 categories (autonomous, dismissive, preoccupied, and unresolved) of attachment style in mothers based on information the parents provide about relationships with their parents. Each of these categories identified in the AAI has a parallel child attachment category: secure, avoidant, resistant, and disorganized (Etezady and Davis, 2012).

As part of the London Parent-Child Project (Fonagy et al., 1993), Fonagy and colleagues studied a collection of 200 mother and father prenatal AAIs in relation to child outcome measures including attachment. Using this AAI analysis, Fonagy and his colleagues began to consider intergenerational attachment and its mechanisms. Through this consideration, Fonagy and his colleagues began to develop particular ideas about mentalization and reflective function

(RF). As a result, a scale was developed to assess RF on the AAI, specifically an adult's ability to reflect upon their own parent's mental states and intentions in attachment related situations. The scale poses questions such as: "Why do you think your parents behaved the way they did?" in order to capture responses "that demand reflection or consideration of complex unobservable mental states" (Fonagy et al., 1998, as cited in Slade, 2005, p. 274). Responses are evaluated on an 11-point scale applied directly to the AAI. A parent's RF (essentially low-high) is assessed based on: "Awareness of the nature of mental states, explicit effort to tease out mental states underlying behavior, the recognition of the developmental aspects of mental states, and the recognition of mental states in relation to the interviewer" (Fonagy et al., 1998, as cited in Slade, 2005, p. 274).

Assessing a parent's ability to consider their own mental states in order to consider the emotions and intentions of another is an important aspect of therapeutic treatment to facilitate secure attachment in the parent-child dyad. Fonagy and colleagues (1993) state:

If the parent's own attachment history was poor, that parent's willingness to contemplate the mental world of self and others may be defensively limited. The coherence of the parents' perception of their past derives from an unhindered capacity to observe and reflect upon their own mental functioning, to have a plausible view of themselves and their objects as human beings, thinking, feeling, wishing, believing, wanting, and desiring. This coherence forms the bridge of attachment security between the generations. It is the precondition for the caregiver's ability to provide an "expectable" or "good-enough" mental environment for the infant. (Fonagy et al., 1993, p. 984)

Clear communication and connection of thoughts and intentions between parent and child can solidify secure attachment and development, but oftentimes the parent needs to address

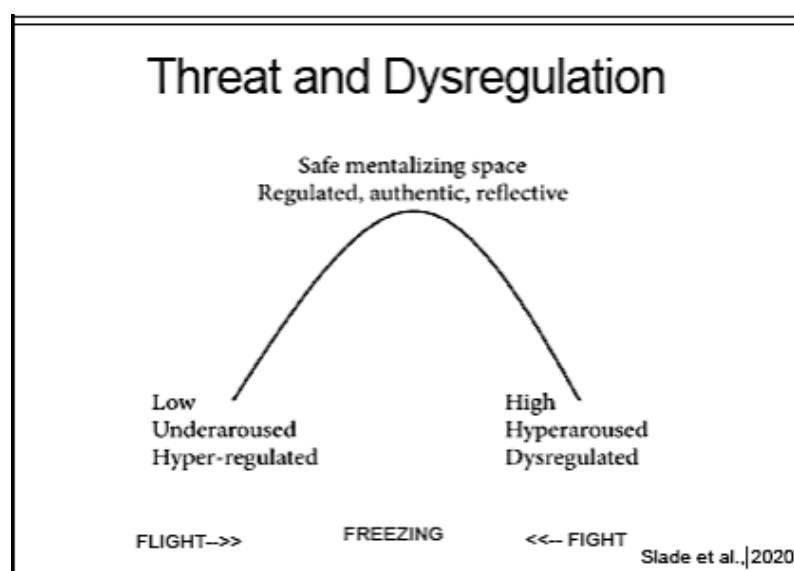
issues at hand that may stifle communication. Whether it is addressing trauma from the past or current frustrations that may be roadblocks to understanding, in order for the parent to be open to their child's mental states, they must begin to explore their own. That often involves being able to share past experiences without the threat of being judged. It is necessary for the parent to find solace and build trust in a setting where they can not only share, but learn from other people who share similar experiences.

One option to build reflective function capacity for parents who may experience parenting stress is a mentalizing-focused, group-based therapy. Reflective parenting programs such as the Reflective Parenting Program (RPP) developed by the Center for Reflective Parenting (CRP) in California, were established to provide a safe space for parents to observe and explore the potential meanings of their children's behavior without the child being present. Groups are facilitated by two group leaders and consist of five to eight parents and meet for ninety minutes on a weekly basis for a minimum of ten weeks. Groups are organized according to the age of the child (from prenatal to high school) and the curriculum of the group is used to introduce the building blocks of reflective thinking. In time, the curriculum shifts towards more emotional and challenging topics in order to provide space for the parent to develop a capacity for reflection before confronting issues which are likely to cause a parent's reflective capacity to break down (Etezady and Davis, 2012).

CRP uses adult attachment styles to understand how parents "tend to manage and regulate emotional experience, including typical defenses, particularly in relation to negative emotions such as anger, fear, anxiety, and distress" (Slade as cited in Etezady and Davis, 2012, p. 52). Trainees are asked to "emphasize a parent's strengths and empathize with their weaknesses" (Etezady and Davis, 2012, p. 53). CRP also supports parents in finding their own

answers as opposed to telling them the right or wrong way to parent. CRP believes in: “Starting where the parent is and first helping her or him feel safe and supported as the primary technique for developing a greater reflective capacity” (Etezady and Davis, 2012, p. 56). Each parent has a unique experience and develops their own capacity to mentalize. If the therapist attempts to provide the answers, the parent may not remain curious in interpreting their own feelings or the feelings of others. Additionally, what works for one parent may not work for the other even in similar situations. Although it can be difficult at times, developing a reflective stance requires taking a step back, self-regulating, and maintaining a calm demeanor even in challenging situations. Examples of challenging situations can include a child is having a tantrum—perhaps screaming or throwing objects—or if the parent has experienced a difficult day at work. Building and maintaining a reflective stance takes time, patience, and work but if the parent is willing, the benefits to the relationship with their child are infinite.

Below is a chart (see figure 1) developed by Arietta Slade and colleagues (2020) that illustrates a variance of mental states. The optimal space for RF is the safe mentalizing space at the top of the curve.



It can be difficult for parents whose child exhibits challenging behavior to feel secure in their parenting and their relationship with the child. Often parents may feel that no one understands them, especially family members, and so the parent may feel that they are not able to trust anyone with their feelings and may even become defensive as a means of self-protection. This feeling can be compounded in situations where trauma is present, with in the community or in the home. In these instances, it can be very difficult for a parent to maintain a calm, reflective stance because the stress is overwhelming and they may feel alone and isolated. The following is an example of how group-based mentalizing treatment can support parents who may feel socially isolated and struggle with understand their child's behavior:

Ann and her son Tony (as cited in Etezady and Davis, 2012, p.55).

Ann, a mother of twins, was anxious and insecure about many things including how to set limits, create structure, and intervene. Her twin son, Tony, was particularly challenging for her; Tony's active and aggressive temperament added to her insecurities. She had difficulty listening to the other members of the group during group therapy sessions and would often offer "advice" although she struggled to decipher her son's behavior. The following is an excerpt of an exchange during group:

Ann: I'm trying. Yesterday I actually made myself not react. I couldn't say anything, but I was able to just sit there. But I don't think you guys realize how impossible this is to do. I can't figure him out. I get so angry so fast and just explode at him. I keep hearing you guys say, 'Stop for a minute,' but I keep feeling there *must* be something specific I should be *doing*."

Group Leader: “There seem to be a lot of thoughts running around in your head and things get mixed up. You feel confused about what might explain what is happening with Tony—maybe a fight with his sister, a tummy ache, missing his dad.”

Ann: “You mean all these things could be related to his behavior?”

Group Leader: “What do you think about that idea?”

Ann: “Yes, there are a lot of things to think about, but when I think about it that way, I don’t feel so responsible to get it right. How can I always know what’s going on?”

The group leaders and group members continued to support Ann and continually repeated phrases like, “Let’s stop for a minute and think about this together,” Ann was able to admit that being a mother of twins was difficult which made her feel insecure; it was challenging for her to slow down. Eventually, Ann was able to say, “Yesterday I told Tony that we just had to be still for a few minutes to try and figure out what happened.”

Here we can see an example of how group-based, mentalizing-focused treatment can help parents to better understand the behavior of their child. Perhaps what is most important is that the group support helped Ann to develop an understanding of what might be going on for the child. The group support is essential in situations where a parent feels socially isolated and alone. CRP is only one of several programs that employ a mentalizing-based approach to better understand the behavioral and emotional needs of the child. Other group-based interventions include: Incredible Years, Circle of Security, and Listening Mothers (Etezady & Davis, 2012). Individual parent-child programs include: Child-Parent Psychotherapy, Minding the Baby, and the UCLA Family Development Project (Etezady & Davis, 2012). If the parent is seen and heard, they may be better able to feel empathetic toward their child’s experience. The ability to understand and be

understood can strengthen the attachment bond between parent and child which can mitigate the intergenerational transmission of trauma.

4. Concluding Discussion

In this paper, I have discussed the diagnosis and current treatment of ADHD and why employing reflective functioning as a therapeutic modality can help strengthen attachment bonds between parents and children. Because attachment is a natural, proximity-seeking mechanism to protect against threat, the child's sense of security relies on feeling protected by the attachment figure, in most cases the parent. Children with ADHD are often misinterpreted and their behaviors are often misunderstood; this is why adopting a mentalizing, reflective stance is critical. The parent is able to model a calm demeanor which also supports emotion regulation in the child. The parent provides a safe haven and a secure base for the child and from this, the child is able to develop autonomy and secure sense of self. Without secure attachment, the child may become hypervigilant to any threat, real or perceived. The child who feels they do not have a source of stability and protection in an attachment figure learns to become mistrusting of others. In the absence of nuanced treatment and care, other challenges may arise such as anxiety and depression.

As illustrated in the case of Alice and PCIT, current therapeutic treatment may not always consider the experience of ADHD for children and their families. Shortly after PCIT therapy concluded, Alice's mom searched for ways in which their daily lives could be improved. Parenting stress levels were high; feeling overwhelmed by the abundance of suggestions and cost of treatment, Alice's mom began to look for low-cost alternatives, something that could help her to better understand ADHD and what her children were experiencing. By chance, she discovered reflective functioning and works every day to consider her own mental state, but also the mental states of her children. She no longer views her children's behavior as oppositional, but sees the

behavior as representative of underlying mechanisms and stays curious to discover what prompts behavior.

Arietta Slade states:

The capacity to reflect evolves from the parent's capacity to hold the child in mind, and the child's experience of the parent's mind as knowable and safe, wherein contemplation of the other's mind is key to intimacy and connection rather than dread. (Slade, 2005, p. 273)

For the parents keeping the child in mind can involve a shift . . . from saying I know my child to saying I am curious and want to understand what is happening for my child. While it is important to understand the child as a separate entity, possessing their own unique mental life, "it is her [mother or caregiver's] capacity to link this awareness of her child's or her own internal state to behavior or to other internal states that is the hallmark of true reflective functioning" (Slade, 2005, p. 278). Parents who are able to adopt a more reflective stance toward their child and the child's behavior may better help the child to self-regulate and to feel loved, seen, and secure. For the caregiver or parent, it is taking the time to listen to the child, not simply in what the child verbalizes but what body language communicates as well. An adult's ability to pause in a moment and to put aside personal frustrations to dedicate attention to a child can be powerful. The child who is seen and understood maintains a sense of self-worth which can be a potent remedy to loneliness and disconnection. It is also important to note that adopting a reflective stance every moment would be an impossible task; parents are susceptible to their own mental states and cannot always be available to hold the child in mind. Expert Peter Fonagy states that if he is tired or anxious, he is more likely to jump to conclusions and misunderstand people's intentions. Fonagy admits he "gets the child right about 50% of the time" but adds that "if

children were perfectly understood all the time, it wouldn't prepare them for real life" (Simms/Mann Institute, 2016).

Alice and Jack Follow-Up

During a recent interaction with her parents, Alice's mother noticed Alice seemed unhappy. When her mother asked her if something was wrong, Alice stated: "I'm in a bad mood." Her mother responded: "I'm sorry to hear that. Why do you think you're in a bad mood?" Alice looked over at her father and said: "Daddy will tell you." Her father remained silent. Alice continued: "I'm in a bad mood because I wanted to stay outside and play and ride bikes, but Dad said it was getting cold and we had to come in." Alice's mother hugged Alice and stated that she was so proud of Alice for being able to communicate her experience.

It has been about two years since the results of Alice and Jack's evaluations and although, there may always be challenges, overall homelife seems harmonious. The path to growth has been steady, but carefully considered for both Alice and Jack. Perhaps the most substantial agent of change took place shortly after testing concluded and recommendations were made. One of the things that has helped greatly is the methylphenidate that was prescribed to Alice that she takes daily. Alice still has challenges with impulsivity and behavior, but she is much better able to consider how she feels and to articulate it. Academics can still be challenging, but with continued support and reassurance, she performs at grade level. She has grown into an avid reader and is very proud of her growing library. Socially, her friendships have gained momentum and she now hosts and is asked to several playdates and parties. Her relationship with her brother, Jack, has also improved and her parents see a much more fluid, respectful interaction between the two of them.

Jack works very hard on managing tasks and improving his academics. An IEP was implemented for Jack mostly to target executive functioning skills and language support. He takes medication to help with focus, but the effectiveness is not as noticeable as it is with Alice. He has reminders (notes and phone alerts) to help keep him organized at home. He is given structure, but also simple, clear tasks that he can successfully achieve. His parents use a lot of labeled praise and spend dedicated time each day to check in with any trouble he is experiencing at home or in school. He is now a black belt in Tae Kwon Do which continues to boost his self-esteem. He is a loyal friend and has developed several new friendships at his new school.

While aspects of growth and positive change for Alice and Jack may be attributed to developmental progress and various interventions, some aspects of growth may have benefited from the reflective stance the parents took. Working to adopt a reflective stance has not only enabled Alice's and Jack's parents to employ more sensitive parenting, but by modeling and asking Alice and Jack about their feelings, the children have begun to understand their own mental states and associated behavior. Alice and Jack work at regulating behavior because they seem to understand and care about how it affects the family dynamic. This may not always be a perfect formula but because they are considered, they consider others. In general, the children seem to struggle less and appear to be more confident. Alice and Jack may face challenges associated with ADHD for the foreseeable future, but their parents are committed to employing reflective functioning and taking a pause to imagine how mental states may be related to behavior. For the most part, these parents no longer respond to negative behavior in a punitive, impatient manner. They realize the importance of trying to imagine what might be going on in the mind of the child and stay curious to figure out how they can help their children to regulate.

Final Comments and Considerations

ADHD is not a fad or a phase; it is a real disorder affecting real families. As a parent, accepting that your child may have a developmental disorder is challenging. Initially, a parent may wonder why their child exhibits the behavior they do; am I a bad parent? Often after a diagnosis is made, parents are inundated with options and suggestions for treatment. What makes the most sense for our family? Can we afford the treatment and where do we begin? How could we possibly medicate our child? This can add to the stress level of an already overwhelmed parent. Although it can initially be overwhelming, the most effective treatment starts with parent education on the disorder and making informed choices based on who the child is. As we have seen, there can be obvious differences in the presentation of ADHD symptoms in children. Whereas inattention is more typical of the diagnosis for females, Alice's presentation of ADHD is hyperactive and impulsive while Jack is inattentive which is not statistically typical in males. Although their ages are different and the nature of symptoms changes over time, Jack never had the difficulties Alice did with impulsivity. His symptoms were not obvious until he was older and his self-esteem and academics began to suffer.

Mentalizing has historically been applied to the treatment of adults with borderline personality disorder (BPD), but has recently been adapted for work with children and families (Midgley et al., 2017) and so may have vast implications for treating other kinds of psychopathology. There have also been several studies that conclude that positive parenting can serve as protective or promotive mechanisms in families with ADHD (Dvorsky & Langberg, 2016). It is likely that the role of caregivers in creating resilience in youth with ADHD will be the subject of an area of expanding research. More research is needed that examines a parent's reaction to their children's difficulties and the impact these types of problems have on

parenthood and family life. It is further necessary to explore how parents experience themselves, their children, and the relationship between parent and child. For the parent, understanding which aspects of raising a child with ADHD are particularly challenging is needed to tailor the most effective therapeutic support for both parents and their children. Important interventions to consider are group-based, mentalizing-focused treatments such as the CRP's program and others highlighted in this paper.

If parents are able to mentalize, they can be agents of support for the child to engage in problem solving strategies as well. This is particularly important in communities influenced by trauma. The channel of engagement must be established and protected in order for the child to feel that they have a secure and trusted source to protect them if and when they encounter threats. If mentalizing breaks down, it may lead to an unnecessary transmission of mistrust and sustained trauma because the child can become "less flexible, less trusting, less adaptable, and less willing to learn." (Simms/Mann, 2016). The consequences of trauma may not only impact success of youth themselves, but it can also impact future generations.

References

- Ainsworth, M. (1991, July). *Past and Future Trends in Attachment Research*. International Society for the Study of Behavioural Development. Minneapolis, MN. Film of the presentation made available by Avi Sagi-Schwartz (Chair).
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*. Arlington, VA: American Psychiatric Association.
- Barkley, R.A. (2013). *Taking Charge of ADHD: The Complete Authoritative Guide for Parents* (3rd ed.). New York, NY: The Guilford Press.
- Bowlby, J. (1951). Maternal care and mental health. *World Health Organization Monograph Series*, 2, 179.
- Bowlby, J. (1988). *A Secure Base: Parent-Child Attachment and Healthy Human Development*. Basic Books.
- Crain, W. (2005). *Theories of Development* (5th ed.) Upper Saddle River, NJ: Prentice Hall.
- Dvorsky, M.R. & Langberg, J.M. (2016) A review of factors that promote resilience in youth with ADHD and ADHD symptoms. *Clinical Child and Family Psychology Review*, 19, 368–39.
- Etezady, M. H. & Davis, M. (Eds.). (2012). *Clinical Perspectives on Reflective Parenting: Keeping the Child's Mind in Mind*. Jason Aronson.
- Faraone, S. V., Rostain, A. L., Blader, J., Busch, B., Childress, A. C., Connor, D. F., & Newcorn, J. H. (2019). Practitioner review: Emotional dysregulation in attention-deficit/hyperactivity disorder—Implications for clinical recognition and intervention. *Journal of Child Psychology and Psychiatry*, 60(2), 133-150.
- Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect Regulation, Mentalization, and*

- the Development of the Self*. New York, NY: Other Press.
- Fonagy, P., & Target, M. (1996). Playing with reality: I. Theory of mind and the normal development of psychic reality. *International Journal of Psychoanalysis*, 77, 217 – 223.
- Fonagy, P. & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, 9 (1997), 679–700
- Fonagy, P., & Target, M. (1998). Mentalization and the changing aims of child psychoanalysis. *Psychoanalytic Dialogues*, 8, 87 – 114.
- Fonagy, P., Steele, M., Moran, G., Steele, H., & Higgitt, A. (1993). Measuring the ghost in the nursery: An empirical study of the relation between parents' mental representations of childhood experiences and their infants' security of attachment. *Journal of the American Psychoanalytic Association*, 41(4), 957-989.
- Fonagy, P., Steele, M., Moran, G., Steele, H., & Higgitt, A. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, 13, 200 – 216.
- Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships. *Journal of American Academy of Child Psychiatry*, 14(3): 387-421.
- Goodall, J. (n.d.). *The Jane Goodall Institute*.
<https://janegoodall.org/make-a-difference/gombe-60/>
- Hallowell, E.M., & Ratey, J.J. (2011). *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood*. New York, NY: Anchor Books.
- Johnston, C., Mash, E.J. (2001). Families of children with attention-deficit/hyperactivity

- disorder: review and recommendations for future research. *Clinical Child & Family Psychology Review*, 4 (3), 183-207.
- Midgley, N., Ensink, K., Lindqvist, K., Malberg, N., & Muller, N. (2017). *Mentalization-Based Treatment for Children: A Time Limited Approach*. Washington, DC: American Psychological Association.
- Ravitz, P., Maunder, R., Hunter, J., Sthankiya, B., Lancee, W. (2010). Adult attachment measures: A 25-year review. *Journal of Psychosomatic Research*, 69 (4), 419-432.
- Rich, A. (1991). *An Atlas of The Difficult World: Poems 1988-1991*. New York: W.W. Norton & Company.
- Simms/Mann Institute. (2016, November 18). *Peter Fonagy: What is Menalization?*
<https://www.youtube.com/watch?v=MJ1Y9zw-n7U>
- Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development*, 7(3), 269-281.
- Slade, A. (2020, February 2). Reframing Aggression: Safety, Regulation, and Relationships. *Demystifying Aggression: Understanding Aggressive Behavior from Multiple Perspectives with Effective Strategies for Promoting Safety and Self Regulation*. Profectum Conference, New York.
- What is Parent-Child Interactive Therapy? (n.d.). <http://www.pcit.org/what-is-pcit.html>
- Winnicott, D. (1953). Transitional objects and transitional phenomena. *International Journal of Psycho-Analysis*, 34(2), 1-15.
- Winnicott, D. (1967). Mirror role of mother and family in child development. In P. Lomas (Ed). *The Predicament of the family*. London: Hogarth and the Institute of Psycho-Analysis.