Attachment-based family treatment of a girl with an ADHD-diagnosis

A case study based on interviews

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Abstract

This is a descriptive case study of a 6-years old girl diagnosed with ADHD, whose family received the playful attachment-based intervention – Theraplay. Before therapy the parents felt exhausted, they could not regulate the girl, who developed symptoms of relational trauma. The article includes a theoretical background based on attachment- and polyvagal theory. Assessment before and after treatment are included and there is a description of the parents and the psychotherapists’ experiences during treatment based on interviews in the final phase of the therapy. The results were analysed theoretically and showed how the child’s relational trauma behaviour decreased and how the attachment behaviour improved. Through feelings of safety, physio-emotional meetings, social engagement, guidance and playfulness the stress levels of the mother were reduced and the parents mentalizing ability became stronger. The study shows the importance of working therapeutically with parents, to give parents and child new emotional experiences of being together and to help parents to develop a deeper understanding of their child. Theraplay has previously been successful in treating internalized problems but this case illustrates that attachment-based therapeutic work can be successful in treating children with ADHD.

Keywords: Theraplay, polyvagal theory, ADHD, relational trauma, mentalization.
The goal of this study

- By a case study illustrate how therapeutic work with Theraplay can be done and examine experiences of the therapeutic process for parents and therapists.

- Analyse the psychological development of the child and parents in the light of attachment theory and polyvagal theory.

- Examine how ADHD interacts with attachment before and during Theraplay.

- Enhance knowledge of what is helpful for a family with relational trauma and a child with severe ADHD symptoms.

Theoretical background

Attachment to the guardian forms the basis of the child’s ongoing development and its exploration of itself, others and the world (Ainsworth, Blehar, Waters, Wall, 1978). During the first two years of life, repeated patterns of interaction create neural circuits and their corresponding inner working models of attachment relationships (Schore & Schore, 1978).

The parent’s sensitive caregiving, attunement and co-regulation is crucial for a healthy development and is the basis for secure attachment and self-regulation. Without the help from a co-regulating other, the child’s brain cannot develop in a healthy way (Shore, 1994). The brain develops from the bottom-up; the brainstem is the most primitive area and includes essential functions of survival, for example, body temperature, hunger, blood pressure, coping strategies fight, flight and freeze. This level of brain is working from birth. It contains, for example, instincts, basic sensory functions and affects. Co-regulation on this physiological level aims to keep the child in a physical regulated state to ensure the survival and further development (Hart, 2008).

Next level, the limbic area, also called the social-emotional brain, develops during the child’s first years of life and is formed by early attachment experiences. This level is the neural base for social interaction, empathy, emotions and patterns of attachment. Co-regulation is about affect-regulation whereas early affects is nuanced to a broader register of emotions (Hart, 2008).

Pre-frontal cortex is developed latest and is unique to humans. It is a very complex system including, for example, functions as cognition, reflection, emotional stability and mentalization. Emotions are nuanced and get transformed to feelings. This area controls deeper levels of the brain and, for instance, makes it possible to control primitive impulses and emotions in a social acceptable way. The co-regulation is on a verbal level (Hart, 2008).
In therapy it is important to address the intervention to the adequate level of brain development. If the problem is on a deeper emotional level it’s not helpful to intervene to higher-level functions (Hart, 2009).

Polyvagal theory (Porges, 2011) assumes that humans constantly scan the environment to detect threats. Porges calls this unconscious process neuroception. Humans are checking cues in people’s faces, voices, body posture and can be calmed or frightened by those cues. When a threat arises, the sympathetic hyper-arousal system gets activated with a fight/flight reaction. If it’s not possible to fight or flee, the parasympathetic system gets activated with freeze reaction. Also, in situations where it is difficult to interpret other people, the mobilizing system gets activated. People with past trauma have an increased sensitivity to cues of threats and can react when there is no danger as well as not react in situation of real dangers.

Porges (2011) describes five physiological states of arousal. Each state is linked to specific behaviors in humans:

- Social engagement, linked to the need for safety, exploration and detection for threats. In safe/optimal states, higher cognitive processes become available and humans can relate joyful, engaging and close to other. This state is the basis for a sense of safety in human relationships and is optimal for learning.

- Hyperarousal, linked to fight or flight reactions.

- Play is joyful and stimulating, it’s linked to both the social engagement system and to the sympathetic mobilization processes.

- Immobilization, freeze reactions, linked to life-threatening situations where the fight flight response is not possible.

- Immobilization without fear, linked to prosocial, positive and restorative processes.

“Even with removal of danger cues, the social engagement system may remain dormant unless it is stimulated with safety cues” (Porges, 2015, p. 120). Thus, feeling safe is the base for human development, the attachment processes and is the basis for therapy.

International research shows that secure attachment is related to an ability to handle trauma, stress and difficult life events in a more adaptive way (Perry, Pollard, Blakely, Baker, & Vigilante, 1995). Securely attached children also accept the guidance and the boundaries set by their parents better than insecurely attached children (Sroufe, Egeland, Carlson, & Collins, 2005). There is thus a scientific basis for supporting the attachment bond between children and parents.

Children with secure attachment have a lower degree of psychiatric symptoms during adolescence (Sroufe, et al 2005). Thus, the internal working models are dynamic and can change to become more or less secure, depending on interaction experiences in close relationships (Bowlby, 1988). Strengthening the attachment bond should therefore be an
objective, regardless of symptoms. Attachment-based treatment can be combined with other treatments such as trauma treatment, pharmacological treatment, etc.

Clinical experience shows that a majority of families who are treated at Child and Adolescent Psychiatry (CAP) have complex, multifactorial problems. They cannot be assessed/treated based on a specific perspective and instead require/need multiple perspectives. Children with neuropsychiatric problems and relational trauma (Allen, Fonagy & Bateman, 2008) are an especially vulnerable group which requires significant parenting ability. A high degree of sensitivity awareness (Ainsworth, Bell, Stayton, 1971) and a reflective functioning (Slade, 2005) is required to support the child in forming a secure attachment. This case study illustrates the complexity of these processes.

Relational trauma damages the attachment system and the ability to mentally self-heal. The state manifests itself in a lack of mentalizing ability, mental illness, and in the child's aptitude for close interaction with other persons (Allen, 2001). The symptoms can be similar to other states, such as depression, oppositional defiant disorder, stress, anxiety, ADHD and autism-like states. The contact behaviour can be characterised by disinhibited behaviour or contact avoidance (DSM 5). There is a high tendency for experiencing shame and trauma behaviours, which take on the fight, flight, freeze coping strategies (Perry, 2006). Research has shown that children in chronic states of stress integrate these behaviours into their personality; "States become Traits" (Perry et al. 1995, p. 275).

What help do families with these issues need?

The attachment process is experienced–based, therefore it is not enough to treat it with verbal/cognitive methods. Parents and children need to experience new physical-emotional meetings (Hart & Makela, 2011). The process of intersubjectivity occurs in face-to-face interaction, resulting in a shared state of feelings and actions, making it possible to synchronize movements and to resonate with another person's feelings, to share meaning and the joy of being together (Trevarthen & Aitken, 2001). Adults and children who are insecurely attached avoid intersubjective meetings because it feels insecure and threatened (Hughes & Baylin, 2012). They need new positive experiences of intersubjective meetings, emotional meetings at the limbic level (Hart, 2008). Therefore it is crucial to work therapeutic on the basis of attachment reparative processes.

According to Schore (2003) therapists who treat relational trauma should:

1. Understand importance of early dyadic regulation; right hemisphere development; formation of implicit procedural memory.

2. Focus on preverbal facial, vocal, gestural communications which develop limbic system, right brain function and affect regulation.

Before starting treatment it is important to identify and clarify the implicit relational processes and the existence of trauma behaviour in both parent and child. The parent's description involves the parent's explicit image of themselves, others and the world. Early experiences are processed at an implicit level and get trigged automatically. They are not
verbally available but they control behaviour to a large degree (Schore, 1994). If the assessments just focus on the explicit narrative, there is a risk that the family will not receive adequate help or that the therapist will reinforce an unhealthy parental trait.

**Theraplay**

Theraplay is an interaction treatment that aims to strengthen the secure attachment-relation. It was developed in the 1960s as part of the "Head Start program" in Chicago. Booth & Jernberg (2010) designed the Theraplay method which is based on dimensions in the early healthy parent-child relation.

Theraplay is a neural exercise of state regulation and stimulates deep levels of the emotional brain. Arousal regulation and the secure interaction between the parent’s and infant’s social engagement systems is the basis of a healthy emotional development. Similar to the healthy parent-child interaction leads to secure attachment, Theraplay strengthen secure attachment processes, modulates fear, stress levels and increases the parental sensitivity in relation to their child (Hart & Makela, 2011). According to Hart & Makela, (2011) and Makela (2014) the deeper emotional structures of the brain must be addressed before mentalizing and symbolic processes can be successful.

In Theraplay the therapist guides parents and children through playful, challenging, attuned and nurturing activities. The sessions are filmed and, parallel to the sessions parental meetings are held with reflections, role play and looking at video sequences from the latest session. This offers a unique opportunity to meet the parent’s deeper emotional brain structures and provides possibilities to strongly develop the parents mentalizing ability (Allen, Fonagy & Bateman, 2008). In order to respond sensitively to the child, a parent must be able to reflect on her own and her child’s internal states (Fonagy, et al., 2002). The ability to mentalize can be blocked when living under stressful situations (Hughes & Baylin, 2012).

Theraplay treatment is based on Marschak Interaction Method (MIM) assessment, a semi-structured, video-recorded interaction assessment which highlights interaction patterns between children and parents. In MIM, the parent and child carry out simple, playful activities together and five dimensions of the interaction (Table 1) are analysed (Booth & Jernberg, 2010). Feedback on the recorded interaction is provided in meetings with the parents, where issues regarding their mentalizing abilities are raised. The MIM part thus includes two assessment levels – the analysis of the actual interaction and the parent’s ability to mentalize their child in the feed-back situation. The aim is to design a treatment that is optimized for the individual family.

In a Theraplay session, the therapist initiates sequences of play activities with the parent and child utilizing the dimensions below, see Table 1. As soon as possible, the parent becomes the leader of the activities and the therapist becomes a coach.
Table 1. MIM-Theraplay is based on following interaction dimensions.

**Structure.** Organization, regulation, safety, guidance.
Supporting research:
- The therapist’s guidance and regulation is the basis for predictability, safety and co-regulated interaction (Makela, 2014).
- Clear and supportive parenting is a fundamental prerequisite for development of the child’s security, independence and self-regulation (Sroufe et al. 2005). Characterized by: Bigger, Stronger, Wiser and Kind (Bowlby, 1988).
- Rather than creating dependency, adult guidance and secure relationships are the foundation of self-reliance; “autonomy grows out of attachment” (Schahmoon-Shanok, 1997, p. 38).
- Children with negative experiences of emotional meetings need new positive emotional experiences for building new positive patterns (Schore, 2003).

**Engagement.** Attunement, social engagement system, now-moments.
Supporting research:
- Based on our knowledge of brain development and the effects of trauma, we need to focus on meeting the child’s emotional needs and find ways to regulate and provide security to traumatized children (Perry, 2006; van der Kolk, 2005).
- The therapist captures child’s ineffective self-regulating by attuning to child’s emotional brain, creating now moments that are stimulating or calming (Hart & Makela, 2011).
- The therapist uses basic forms of social engagement to create safety, for example eye contact, soft and warm voice and emotional attunement. The parent’s and child’s experience of safety is therapeutic in itself. The sense of safety reduces the need for defence strategies and allows a therapeutic work. It also facilitates the development of calmer and healthier emotional states (Geller & Porges, 2014).

**Playfulness.** Joyful interaction, pleasure, cooperation.
Supporting research:
- Joy counteracts negative emotions, is stress-reducing and frees up creativity. Children who have not played interactive games compensate by playing too rough at the wrong time (Panksepp, 2007).
- Play activates positive arousal, endorphins and dopamines which produce a sense of being alive, vital and full of energy. Play creates new neural pathways which develop the affect regulating ability (Sunderland, 2006).
- Play can facilitate learning: Play requires reciprocal and synchronous interactions using the social engagement system as a regulator of mobilization behavior. Play fosters the calm states that optimize learning in the classroom and social behaviors (Porges, 2015).
- Panksepp argues that rough and tumble play promotes pro-social regulatory functions of the frontal lobes (Panksepp, 2007). He posits that more free play would reduce the incidence of ADHD. “Any therapists who can capture the therapeutic moment in mutually shared play episodes will have brought the client to the gateway of happy living” (Panksepp, 2009, p. 17).
In Theraplay the therapist uses his/her own social engagement system, facial expressions, voice, and body language to activate the child’s and the parent’s social engagement system for creating a sense of safety (Lindaman, 2016). In the playful Theraplay activities the therapist express that this is fun and not threatening, which increases the feeling of safety and regulates mobilizing systems (Lindaman, 2016).
Theraplay treatment phases

Table 2. Theraplay treatment phases.

- Intake interview, the child-parent history.
- MIM interaction assessment.
- Feed-back of MIM.
- In-depth parent interview, parent's own attachment experiences connected to the parenting role. Psychoeducation.
- Theraplay sessions for parents. Reflections and role play with parents. Formulate goals for the Theraplay treatment based on the five dimensions.
- Theraplay sessions with the child and parents. The playful activities is based on the dimensions and aims to provide children and parents with new, positive experiences of being together. Parallel meetings with the parents, focusing on improving the parent's mentalizing ability. The intensity and frequency of the work with the parent is based on an assessment of their emotional needs and their need for guidance.
- At the end of treatment: A follow-up MIM.
- Check-up sessions over the year.

Previous research

Theraplay has been used with good results in a variety of different symptom and groups such as mothers and children’s experiences of domestic violence (Bennet, Shiner & Ryan, 2006), speech disorders and shyness/social anxiety (Wettig, Coleman & Geider, 2011), children with mental health problems (Makela & Salo, 2011), adolescent behavior and beliefs about himself and others (Robison, Lindaman, Clemmons, Doyle-Buckwalter, & Ryan, 2009), children with internalized problems (Siu, 2009), adoptive families (Weir, Lee, Canosa, Rodrigues, McWilliams, & Parker, 2013). This study is needed because we don’t know much about the treatment processes and the parent’s experiences during the treatment.

Case study

The case family consists of biological mother and father and two children, identified patient Sara, 7 years and her little brother, 5 years.

Case history based on interviews of the parents

The parents explained that they experienced problems with Sara directly after birth. For the first five years Sara was constantly dissatisfaction with strong body tensions. She slept very little as an infant. During the short periods when she was sleeping, her screams still
rang in the parents’ ears. It was hard to change her diaper and nurture her – “she wriggled like a worm on the changing table”. Sara’s signals were hard to read, they did not perceive any rhythm in her behaviour. She had a very high activity level, avoided eye and bodily contact and it was often impossible to make contact with her. The parents did everything they could to support Sara but nothing worked. The contact difficulties were the most painful: “She may have screamed, but her pushing us away was the worst”.

The girl’s presence had always given the parents a high baseline level of stress and they dreaded weekends and holidays when she was not in school. Impulsiveness and hyperactivity were always at the forefront - a normal day would include around 50 to 70 conflicts. One parent always stayed close to her as she was a danger to herself and others.

The story also included the girl’s strengths, her good sides, Sara was described as creative, eager to learn, being able to read and write at the age of five.

The parents stated that they had sought help early but that they were questioned rather than listened to - first by the child care centre, then the social services and then by the CAP. At the child care centre they were told that Sara’s behaviour was a normal part of a developmental phase. The parents felt like they were dismissed and disrespected.

The social services were brought in when Sara was 18 months old. They offered several sessions of milieu therapy. The parents stated that they felt positive about this, having been acknowledged and taken seriously. The matter of CAP was brought up but they were rejected and told that CAP does not conduct ADHD examinations for children under 6 years of age. When Sara was four years old they were offered specialist help. The parents felt that it took far too long before they received help, and that they were rejected and not taken seriously. "It's something you would not wish on your worst enemy.”

Method

A child therapist and a parent therapist, both licensed psychotherapists, worked on the case. They are co-writers of the article, author’s number three and four.

The study is based on interviews with parents and therapists in the final phase of the therapy. The interview with the parents was conducted in two meetings, with both parents present. The therapist interview was conducted with both therapists. The principal author did all interviews.

As a complement to the interviews, parental stress was measured by SPSQ (Swedish Parenthood Stress Questionnaire) (Östberg, Hagekull & Wettergren, 1997) which is a self-report instrument, measuring parental stress. SPSQ consists of 34 items, which are estimated on a five-point scale, where parents should mark degree of agreement with each statement. High scores indicate a high level of parental stress. The instrument has five subscales; incompetence, role-restriction, social isolation, relations between spouses and health problems. In a population-based sample mean was 2, 52 (Östberg, Hagekull & Wettergren, 1997). Both parents filled in SPSQ at the start and at the end of treatment.
Clinical assessment at the start of treatment

- Sara was born difficult to soothe with neurological impairments, which were diagnosed as ADHD at the age of four.

- During her first years her physical arousal could not be regulated by parents - in highly aroused state she may experience baby version of fight, flight, freeze. This is where the fear would come from - a neuroception of danger (Porges, 2011).

- As Sara developed later in baby hood, parents were unable to co-regulate emotional arousal either and did not get to synchronize, attune, repair, experience moments of meeting and intersubjectivity, that leads to a relational trauma.

- Parents were disconnected, they did not feel safe and they were in a state of mobilization. They felt inadequate, exhausted, rejected, angry and misunderstood by others.

- Parents and Sara’s social engagement system was characterized by threat. Their interaction was not characterized by mutual synchronization and safe face-to-face.

- Sara’s extreme dysregulation suggested shame and humiliation. Prolonged negative states and lack of repair can be toxic to the developing brain leading to long term negative effects on processing of social-emotional information, regulation of body states, coping with emotional stress and development of the emotional and body self according to Schore, (2003).

- The pre-treatment MIM showed common themes for both parents. Signs of reverse hierarchy especially in the structure and nurture dimensions. The parents did not take natural responsibility over the activities, the girl was in charge. It was easier for the girl to give than to receive nurture. The same pattern aroused in playfulness, the girl took most of the initiatives. She easily got dysregulated and the parents had problems to regulate her. Sara also showed restricted check-back behavior. The parent’s level of challenge was shifting, in some sequences too high and in other more adequate.

- In the MIM-feed-back situation the parents showed problems mentalizing their child. They had lived under high stress for such a long time so it was uncertain whether if it was a primary or blocked issue (Hughes & Baylin, 2012).

- At the start the result of SPSQ, total scale for the mother was 4, 12 and for the father 3, 10.
Treatment plan

Sara was 4.3 years old when the MIM assessment was carried out. The girl was 5.0 years old when she began Theraplay treatment. The goal for treatment was to strengthen parents’ empathic understanding of their daughter, their ability to co-regulate her and strengthen the parents and child’s interaction in a healthy way.

Although parents usually participate in the treatment room with the child, initially these parents and the parental therapist observed the child therapist and child interaction from behind a one way screen. The reason for this approach was that parents were exhausted and did not have the strength to actively meet the girl in play. The goal was helping parents to see new aspects of child and observe how the child therapist interact as a model. As soon as possible therapists and Sara participated together in the sessions.

The treatment was ended when Sara was 7:3 years old. The treatment included 35 play sessions and a similar number of parent meetings. Her treatment course lasted much longer than typical Theraplay treatment does, due to the complexity of the case.

Before and during the treatment, the family was offered pharmaceutical treatment for the ADHD problems, but the parents declined.

The child treatment process, interview with the therapists

Start-up phase. In the first two sessions Sara showed an over adapted behaviour (freeze) but after that she started to forcefully try to avoid interaction (flight). The child therapist was attuned and inventive; activities were focused on joint experiences rather than direct you-and-me meetings. It was extremely difficult to get close to Sara. When the therapist tried to catch her attention, she became even more active. At the start, the therapist and child went into the room holding ends of the same thread, as a connection link, a way of regulating Sara. As the girl reacted strongly to physical contact, new ways of staying together were devised through games that did not require much physical contact for example blowing and catching soap-bubbles in different ways. Progress, which they experienced together was described as "incredibly fun but difficult".

Shame was manifested in flight behaviour with elements of freeze. The Theraplay approach to just being with her in a way that sparked her enthusiasm and curiosity was successful, Sara’s fear subsided, and the child therapist could introduce more traditional Theraplay games with a clearer structure and a direct you-and-I focus. Sara eventually was able to participate joyfully in engaging, playful activities and also accept physical touching as a natural part of game such as short sequences of hand clapping games. The theme was intimacy – distance.

During the first phase it was assessed that Sara’s underlying feeling was shame, danger and fear of intimacy. Therapist: "Sara’s identity and self-image has been that she is the kind of person who does things wrong and someone people are angry at. Experiences of being in a close relationship were associated with anger, intimacy was frightening and
being close to someone meant an angry body, tone and words. Intimacy triggered shame and she was used to the person she was with becoming angry at her.” Eventually the shame subsided and Sara dared to stay in close contact for longer periods. The hyperactive behaviour persisted but she began to accept a certain degree of co-regulation.

Work phase. The development was described as a continuous process, while interaction was characterised by reciprocity. The relationship became more trusting, trauma behaviour transitioned into constructively working with intimacy and distance in the interaction. Playfulness, engagement and challenge levels were important dimensions, Sara loved to tap a balloon back and forth with the therapist. Her sense of safety grew and the ability to participate in non-threatening activities gradually increased and gave her experiences of positive interaction. The sequences of play were extended and at the same time she experienced mutual meetings.

When Sara accepted co-regulation, the parents began to participate - the mother first - into whole sessions. Sara reacted with increased hyperactivity but could still be regulated.

Concluding phase. Sara’s attachment behaviour was changed and the child therapist perceived a completely different relationship with the girl. Whereas they had held a physical thread between them at the start of the treatment, there was now an invisible thread between them. The therapists stated that the girl started to express herself verbally and asked what is okay and what is not, rather than acting out. Both parents and both therapists took part in the interaction. Sara became more hyperactive but still remained adequately composed and in contact. She became much more accommodating and had a greater comfort level with the physical contact between her and her parents. During this phase Sara enjoyed nurture activities from the parents such as massage, care of hands and feet.

The parents' treatment process as described by the therapists

Start-up phase. The start of the treatment was hard for the parents. Sara's problems became so clear, while their feelings were acknowledged and verified. The parents’ therapist tried to capture their feelings in order to allow them to be verbalised and reflected on. This was a difficult process; the parents were stressed and frustrated. The therapist felt that they were hard to read; their ability to reflect was limited and their emotions were on an implicit level. The strong feelings manifested as physical tension. The parents’ therapist felt that he had been too active in his attempts to reflect on the feelings that were aroused in the parents, and he subsequently focused more on just be with them and try to mentalize their feelings.

Work phase. During a process of around 15 sessions the stress level fell continuously, the physical tension subsided at the same time as the ability to emotionally reflect increased. They experienced that Sara expressed increased trust and their feeling of hope was strengthened. The process became increasingly focused on helping the parents verbalize their feelings and on jointly "getting to know" Sara. They became more active in parenting and more emotionally accessible, and the parents' therapist began to see that the work
already expended had been very important. Insight and the ability to reflect grew continuously and were explicitly formulated by the parents around six months later. Their attitude toward Sara changed, characterized by empathy and a will to understand her even better.

Concluding phase. The treatment focused on how to understand the intentions behind Sara's expressed behaviour. The parents needed the therapist’s concrete support in the early stages of this process. The reflection process now continued more independently in their daily lives. They wondered about what she was experiencing emotionally and how they could engage with her.

The reflections have gone further and included the parents’ own attachment experiences as part of an emotional understanding of themselves, their parenting and of Sara. They now see similarities between themselves and Sara. Themes from the assessment phase can now be processed in a new, more explicit way. The therapists described a process where both child and parents went from insecurity to security.

The parents' description of their experience of the treatment

The parents saw no progress during the first 5-6 sessions. Sara become excitable when she came to CAP and they felt irritation when they saw Sara’s behaviour, the experience was both painful and a guilt-relieving confirmation of how hard it is to interact with Sara. They wanted things to move along faster than what they now realize was possible. However, they could communicate this frustration to the therapists. The reason why they still wanted to continue with the treatment was that they felt like they were finally believed. They also found it valuable to watch and reflect on how the child therapist approached Sara, how difficult interaction situations were handled and they were able to put words to the feelings that arose when they interact with the therapists. Father: "Valuable and educational to watch while we have talked to the therapists about things we recognise, the feelings that arise and how we can approach her. Finding new ways to give Sara experience of mutual joy."

It took approximately 6 months before the parents saw that the treatment had a real effect. Sara was no longer as focused on controlling and directing activities, she paused and she listened more. Her laughter went from being high pitched to being genuine laughter. The parents described the changes as not only occurring within Sara, but that they as parents also had become better at engaging with her.
Clinical assessment at the end of treatment

- Sara’s hyperactivity was decreased.
- Parents and Sara’s social engagement system was characterized of reciprocal joy, closeness and playfulness. Because of their past experiences, unsafety was easily trigged for both parents and child.
- The parental and child’s self-esteem had been strengthened.
- The level of stress was decreased and their ability to mentalize was increased.
- The parents had repaired the relation to Sara and were after treatment able to co-regulate her emotional arousal.
- The emotional meetings increased Sara’s feeling of security which promoted her psychological development.
- MIM at the end of treatment showed improvement for both parents in structure, engagement, nurture and playfulness. The biggest improvement was in the engagement and playfulness dimensions. The reverse hierarchy in the structure and nurture dimensions was decreased. In challenge no change was noticeable. The interaction was characterized of reciprocal playfulness and mutual meetings. The girl’s check-back behaviour had improved and her controlling behaviour was decreased. Both parents and Sara enjoyed each other’s company during the MIM-session.
- At the end of treatment the result of SPSQ, total scale was 3, 44 for the mother and 3, 10 for the father.

The parents' view of what has changed in the family during the treatment

The parents stated that physical contact has increased: Sara will now come up to them wanting to be hugged, ”she looks for us more than we chase her”. When she is sad she seeks them out to be comforted, whereas in the past she would become angry and suppress her tears. Sara has also become better at controlling impulses and verbalizes instead.

Both parents felt that they now understand Sara better. They emphasised the importance of understanding the needs underlying her behaviour in order to interact with her and become better at helping her.

The parents described a process from emotional reactions to conscious actions where Sara was open to communication and can ask her parents for help instead of solving everything on her own. They were now allowed to be part of Sara’s world; she shares her experiences
with them, looks to them for support and affirmation. It allows them to feel better about themselves as parents. The number of conflicts have reduced massively to around three per day, which means that they have the energy for better conflict resolutions which in turn leads to a better interaction process.

Sara has become better at social interactions and reflects on how people treat each other. The treatment has improved Sara’s self-confidence and her ability to regulate herself. “All our training improved her self-esteem”.

The parents believed that the therapy’s effect was based on a combination of the interaction training and the parents’ reflections and understanding of Sara together with the therapists. The treatment has provided them with new ways of interacting with Sara at home and a positive spiral was established. Sara is now more attentive to her parents as she notices that they are trying to understand her. The increased understanding of Sara also meant that the parents are able to advise the school staff, which has improved their feeling of parenting competence. The parents see that their actions help Sara to function, and they help her develop her positive creative sides. “All our training improved her self-esteem”.

The parents understood that there is a standard procedure for the Theraplay treatment but they strongly felt that the treatment was adapted for them and their problems – that it was tailored exactly to their and Sara’s needs both in a short and long-term perspective. They stated that it would not have worked to have Sara treated individually, the sessions would not have worked if they had been isolated from the parents’ side of the treatment. Their ability to influence things has giving them a sense of agency and a better self-esteem.

The father described the treatment as “weighing and examining all parts in different contexts.” The goal was to gain good insight into Sara and themselves as parents, to get to know Sara on a deeper level which entails understanding her problems in order to handle various situations constructively. Mother: “I have gone from thinking that it’s my fault, to understanding.” Father: “We have had a great education. We can never hit rock bottom, perhaps a bit further down but not all the way. Nobody can take the knowledge you have gained away from you.” “It has helped the whole family.”

Finally, the parents reflected on the interview experience. “Previously we never understood why she acted the way she did. I realize now that I could not understand her then. I also realize why others do not understand, it has taken us seven years. You become better at taking in people’s comments regarding Sara’s behaviour since you feel more secure. I used to take offence at comments, but now I realize that they just cannot understand. We are more humble towards others now.”

The therapists’ reflections on the treatment process

"Neither the parents nor Sara have previously had a chance to experience intimacy together, to look into each other’s eyes, or to experience mutual meetings together. Sara has had such a high activity level and been so tense that it has been impossible to approach
The relationship with Sara has led them not daring to view themselves as natural parents. Now the family are on their way to changing this.

The therapists felt that they have helped spark the parents’ empathy and understanding of Sara, describing the process as a gradual increase in mentalization. “Through attunement and playfulness, the whole family has been able to grow. The joy and laughter has united them”. The therapists gave an example: "Just think about what a small, harmless balloon can do – you can’t help but be affected. The father stepped on a balloon, giving it another shape. Everyone laughed, it was a good moment”.

The relationship with the parents was described as a parallel attachment bond with the therapists representing adult parent functions. The parents have shared their feelings and they have received helpful support. An important aspect was sharing the difficult parts and the fact that the interaction was challenging also for the child therapists strengthened the alliance.

The gap between the feelings and the physical expression was initially great for the parents; "We could see that tears were shed but the feeling could not be expressed verbally." The development has clearly progressed from preverbal to verbal. To be able to mentalize Sara, the parents first needed to be mentalized themselves. We have tried to highlight the implicit and harboured that until the parents made it their own. There really has been a change and it is important to harbour until the spiralling, reciprocating relationship emerges. An intersubjective process emerges where internal models change and is complemented by new ones."

What the therapists said about working with the Theraplay method: "It’s a powerful and intimate method and you must be aware of what it does to you and what it does to children and parents. You need to be sensitive and have awareness of your own implicit patterns.” "I have been given access to new channels within myself in my role as therapist; the play frees you up and has an effect that spreads to other parts of your work.” "It’s not only about building relationships in families, but about modern developmental psychology in practice.”

Discussion

According to the interviews, parents and child have experienced emotional meetings, they have met someone who is "Bigger, Wiser, Stronger and Kind" (Bowlby, 1988). Through security, attunement, play and alliance, the fear and the stress level of the child and parents was reduced which in turn allowed the parents’ mentalization ability to increase and made it possible to assimilate and accommodate new reparative experiences.

The experienced decrease of parental stress after treatment was also shown in the mother’s result of the SPSQ assessment. The father’s assessment did not show any changes in SPSQ, although in the interview he described a decreased stress level after treatment.
The study showed that the girl’s attachment behaviour and the parents' mentalizing ability developed throughout the therapeutic process. A prerequisite for this process was the therapeutic meeting to deeper emotional structures of the brain (Hart & Makela, 2011).

The emotional lives of both the parents and the child have changed. From negative, separation-inducing emotions, a higher degree of positive, approaching emotions were expressed as a force in the work to repair the relationship.

Under safe and empathic conditions, the parents have repaired the relationship to their child and got closer to themselves and their child. The development has followed an intersubjective spiral, from listening and observing to emotional and active participation, from reacting bodily to stress responses to emotionally reflecting on their own inner being and on their child’s. Using mentalization and harbouring, the therapist regulated the parent’s emotions and supported the parents’ implicit processes to increase their reflection and self-awareness abilities.

The parents and therapists described a process where the girl's attachment behaviour gradually changed from panicked avoidance to expressing genuine needs and receiving satisfaction of those needs. Sara’s self-esteem increased during the treatment.

The girl’s strong reactions at the start of the treatment indicate that the attachment trauma was activated through intimacy. It was expressed through flight strategies with elements of freeze. Building trust through interactive reparation processes took time, but once the foundation had been laid, the development of a co-regulation process was begun. When safety increased, the check-back behaviour and capacity for deeper reciprocation increased.

The hyperactivity remained but was not as marked and trauma-related. The girl accepted co-regulation to a greater degree and enjoyed the activities. In the concluding phase, the interaction between parents and child was characterised by increased security, playfulness and joy of being together. The girl developed strategies for functioning better in school with peers. The parents developed an understanding of the girl's needs and strategies for making the interaction work. They felt that the dialogues with the therapists strongly contributed to the success of the treatment.

Initially, Sara expressed both hyperactive and relational trauma behaviour. The two were difficult to differentiate, but throughout the process, Sara became more secure and the fear-conditioned behaviour subsided as the treatment progressed. During the concluding phase there was still a general tendency towards hyperactivity but Sara accepted a co-regulating other. At the end of treatment she could pause in intimate nurture situations with her parents.

The study showed that attachment-based treatment was helpful for a child with ADHD and relational trauma. The need for early interventions was highlighted. If the family had received help during the girl’s first years, much of the suffering could possibly have been avoided and the treatment period could reasonably be expected to be shorter.
**Strengths**

The study includes several perspectives; those of the parents, the child, the therapists, those relating to ADHD and to relational trauma. Theory was used in interpretation of the therapeutic processes.

**Weaknesses**

The treatment period has been long and it is hard to pinpoint what in the development is the result of the treatment and what is the result of biological maturity. Since it based on one case it cannot be generalised.

**Clinical implications**

The case showed that healthy development and mentalizing ability is possible when child and parents have a basic sense of safety. Safety cannot be created on the basis of higher cognitive processes; it requires physio-emotional meetings to the deeper structures of the brain. Play signals joy and happiness and not aggression (Porges, 2015). Playfulness is an important factor in treatment, it reduces stress and frees up creativity (Panksepp, 2007) which is crucial for a positive therapeutic development. The feeling of safety and playfulness is crucial in all forms of therapeutic treatments and it is consistent with attachment theory and polyvagal theory.

The importance of incorporating several perspectives into the assessment has been highlighted. In complex cases the therapist must have in-depth knowledge of general psychotherapeutic work which allows them to meet needs on different levels. If the therapist had not noted the girl’s fear-conditioned behaviour and had not had knowledge of trauma behaviour, then the consequence might have been that the girl was forced to change her coping strategy from flight to freeze. The freeze stage can easily be confused for a state of acceptance as the child shuts down emotional needs and over adapts to a situation from which they cannot escape (Perry, 2006). If only the neuropsychiatric diagnosis had been used, the treatment may have reinforced a destructive strategy to adapt to an unhealthy environment.

The study shows the importance of working therapeutically with parents, to give parents and child new experiences of being together. A great deal is required of the parents of a child with ADHD. Even if the parents have positive internal working models, the stress and frustrations can block the mentalizing ability (Hughes & Baylin, 2012). The parents in the case described difficulties to meet the child’s emotional needs, the basis for developing a secure attachment relation. It raises the question if ADHD is a risk factor for attachment disorder which would indicate under diagnosis of relational trauma. The existence of attachment disorders in children with ADHD could be high and this question needs to be further examined.
The study shows the importance of interaction assessments of the parents' implicit, ability to meet the child's basic emotional needs. Explicit descriptions do not help us find the fundamental problems, which is a prerequisite for optimal interventions based on the individual family's needs.

The case-study showed that complex cases can be helped by playful attachment-based treatment and there is a need of further research at this topic.

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**Conflict of interest**

The authors declare that they have no conflict of interest.

**Ethical approval**

All procedures performed in the present study were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

**Informed consent**

Informed consent was obtained from the parents included in the study. They have read and approved the article before publishing. The study was approved by the Regional Ethical Review Board in Umeå, Sweden, Dnr 2011-419-32M (tillägg till dnr 08-166M).
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