Trust & Attunement with Children
2 Case Studies

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Part 1

The importance of attachment theory, attunement, trust, noticing, meaning and choice making, authentic shared experience, non-coercion.

The importance of Connection

Abstract

This qualitative case study explores using eye movement desensitization and reprocessing (EMDR) therapy informed by attachment and neuroscience research about the importance of safety (trust) and relationship (attunement). This was chosen to enable a young child to create vital positive neural networks and process early trauma while remaining within the window of receptivity, despite issues of avoidance and control. A single case study design was used with a 5-year-old child who experienced early traumas. Observable symptoms included separation anxiety, avoidance, compromised motor skills, and compromised speech. Data were obtained from carer, child, and teacher report, notes, observations, case file, ratings of emotions, and behaviors. The data were explored for outcome data points, validity, and protocol adherence. Key findings were that EMDR used with attunement and trust-building strategies appeared to support developmental progress while facilitating pervasive post- traumatic growth. EMDR appears to offer appropriate opportunities for incorporating neuroscience and attachment research in order to facilitate trauma processing. Future research into EMDR story- telling procedures and possible causative relationships between trust-building and attunement with neurodevelopmental markers would be a possible next step.

Child 1

- In care since under 6 months old
- On arrival in foster care:
  - vomiting on exposure to loud noises and shouting
  - never learned to crawl
  - all milestones were delayed

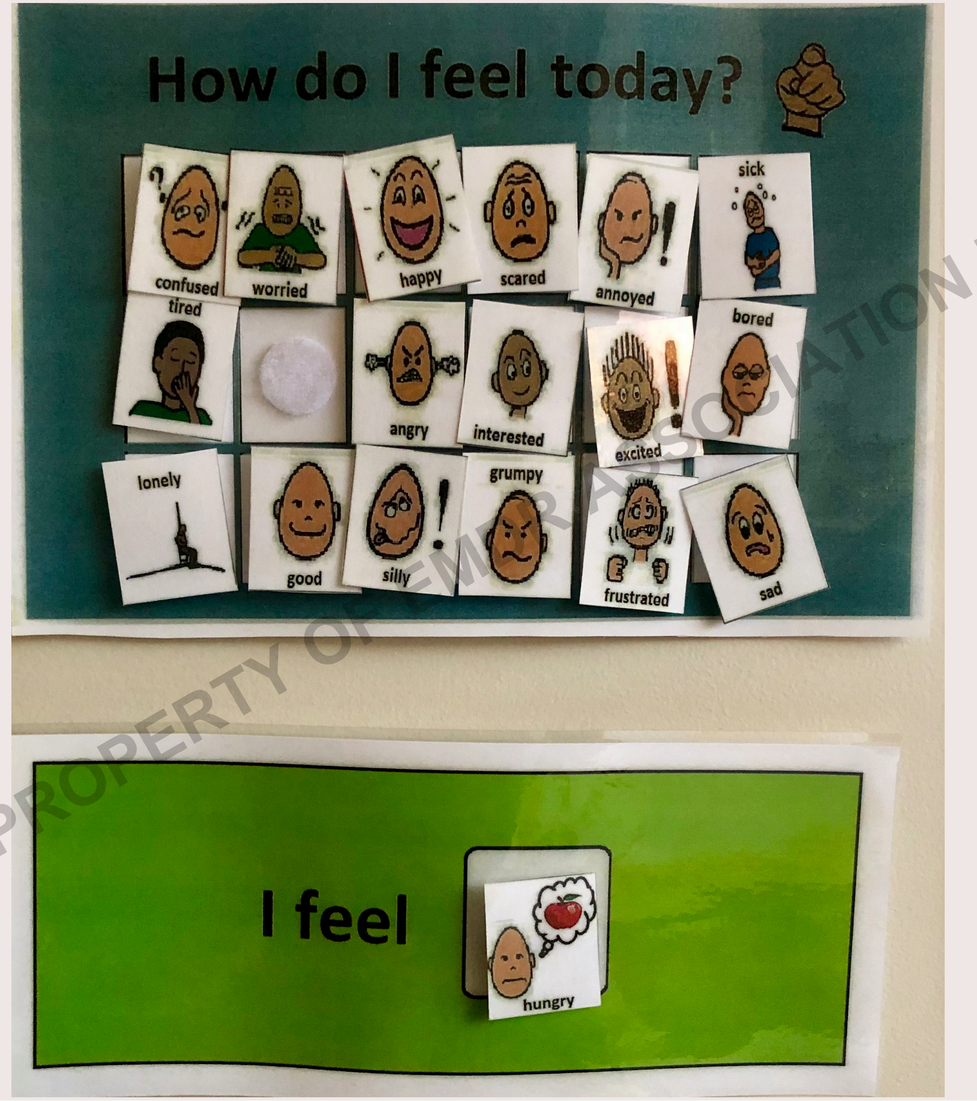
Child 1 - aged 5 years

- presented with: Early Attachment & Family Violence Trauma
    - separation anxiety, panic attacks (with vomiting), sleep difficulties, afraid of going to school and the children there
    - speech and language difficulties (symptoms recorded as atypical of a communication disorder)
    - generalised defensive avoidance and control behaviours
    - compromised fine and gross motor skills
    - features of a dissociative nature (e.g. being tired, freezing, and having a blank gaze)

What did we do?

- 18 sessions with child and carer over 6 months
- Focus on attunement and trust building
- Doing what was needed while being careful not to do to
- Including reflection, options for choice and control, with validation
- Using play and creative activities

SUDS of a Kind



Picture F

SUDS by Session

TABLE 1. by Session

Subjective Units of Distress Scale

Session	Time 1: Start of Session	Time 2: End of Session
Session 3	8	2
Session 4	8	4
Session 5	8	2
Session 6	4	0
Session 7	4	0
Session 8	0	0
Session 9	0	0
Session 10[a]	8	3
Session 11	8	2
Session 12	2	0
Session 13	0	0
Session 14[a]	8	0
Session 15	8	0
Session 16	0	0
Session 17	4 (ending)	0
Session 18	0	0

[a]Denotes the occurrence of destabilizing or traumatizing incidents just prior to session.

Markers of Attunement

Markers of Trust and Attunement	Sessions 1–3 Examples	Sessions 16–18 Examples
Eye contact with therapist	Little evidence: not looking at therapist, hiding face	A lot of evidence: looking at therapist, nonverbal communication, smiling
Body orientation to therapist	Turned away, holding on to carer	Turned toward or straight
Controlling (mistrust - defense)	A lot of evidence: distracting carer from task, e.g., bringing up nonrelated events, refusing to take part orally (saying no) and behaviorally (head and body turned away, no eye contact)	No evidence
Participation and communication	None to very little: not talking, not engaging with toys or therapist	Fully participating and initiating: talking, choosing activities, sharing information, actively contributing to Phase 4 processing and to activities.
Exploring and play (secure base)	None to very little: not getting off carer's lap, not looking at or showing interest in toys and materials	Exploring and sharing new ideas and new play: sitting on own chair, choosing own toys and materials, trying new activities
Doing new things	No evidence	Evidence of many new actions,□e.g., riding pony off lead, riding bicycle without stabilizers, swimming in sea, going out with dad, going to city center shopping center
Leading play	No evidence	Initiating the use of materials and activities and leading new activity (dance) in last session
Appropriate independence	Holding carer's hand tightly, sitting on carer's lap and holding on to her tightly	Sitting on own seat and walking/skipping down hall by self.

Markers of Neurological Development

TABLE 3. Change in Markers of Neurological Development Over Sessions

Markers of Neurological Change	Sessions 1–3	Sessions 16–18
Speech	Multiple letter substitutions in each word including first letter. Carer and therapist unable to understand child's speech. Short single sentences.	Able to pronounce a wide range of words correctly and no first letter substitutions. Carer and therapist have no difficulty understanding child's speech. Able to use multiple sentences, including longer sentences.
Fine motor skills	Writing single letters with letters poorly formed.	Writing multiple sentences with more correctly formed lettering.
Drawing	Figures with head and legs only. Single or few colors.	Figures with head, hair, facial features, arms, legs, bodies, and awareness of foreground. More use of varied colors.
Coordination and gross motor skills	Balance poor and tripping over own feet. No evidence of skipping or dancing.	Able to dance, skip, and leap. Requesting ballet lessons.
Play	No/very little evidence of any play in early sessions.	Creative play seen in many sessions and initiating play and sharing play with therapist and carer.
Separation anxiety	High number of separation anxiety behaviors daily (e.g., clinging, crying, screaming).	None.
Creativity	No evidence of creativity in early sessions.	Evidence of creativity, including making up stories with toys, making up dance moves and songs.
Social engagement	No friends	Friends at school and locally

TABLE 4. Co-occurring Markers of Trust and Attunement and Neurological Functioning

Co-occuring Markers of Attunement and Neurological Functioning

Session	Negative Markers of Trust and Attunement	Negative Neurological Markers	Positive Markers of Trust and Attunement	Positive Neurological Markers
1–3	No/little eye contact Body turned away No/little participation No/little exploring and play☐Avoids new things Controlling others Separation anxiety Distressed at contact with biological mother	Compromised speech Compromised fine and gross motor skills. Poor coordination. Poor sleep☐No/little creative play No social engagement		
9			Good eye contact,☐body turned toward, participation, communication, play, and exploration. Doing new things and increased independence Asking about mother Going into school on own No separation anxiety or controlling others	Clear speech☐More detailed drawings Sleeping well☐Improved fine and gross motor control, e.g., writing and drawing balance☐Increased interest and skills in friendships☐More creative play☐Riding bike without stabilizers
	No/little eye contact Body turned away No/little participation No/little exploring and	Compromised speech Compromised fine and gross		

Case 2

Child 2

- aged 8 years
- presented with:
  - blood phobia (transgenerational)
    - including fainting and vomiting e.g. if hear word “blood” or see anything biological - missing some school
  - needle phobia - no needles since a toddler
  - severe medical anxiety e.g. dentist and doctor
  - unable to have recommended surgery due to extreme anxiety
  - trauma - fainted due to gory image on TV aged at under 2 years old

Presentation

- tendency to become frozen in fear
- very compliant - suggesting powerless and voiceless unable to say no
- never fainted in sessions - keep in the Window of Tolerance (Siegel, 1999)

Timeline

Taking the time line further back from time of the birth of the client identified that the blood phobia was transgenerational

What did we do - needles

- Initial SUDS 10/10
- Titrated storytelling using preverbal early vaccinations and being held down inviting curiosity about her experience and feelings - scared and angry - visible responses in face and body
- Using stuffed toy and carer as resource plus happy place
- Some parts work to encourage safe awareness of all feelings not only “acceptable good ones”
- Some somatic work to encourage SAFE awareness of facial and body responses in the moment
- By end covering the whole story in detail including the scared and angry feelings
- End SUDS 0/10 VOC 7/7 Bodyscan clear

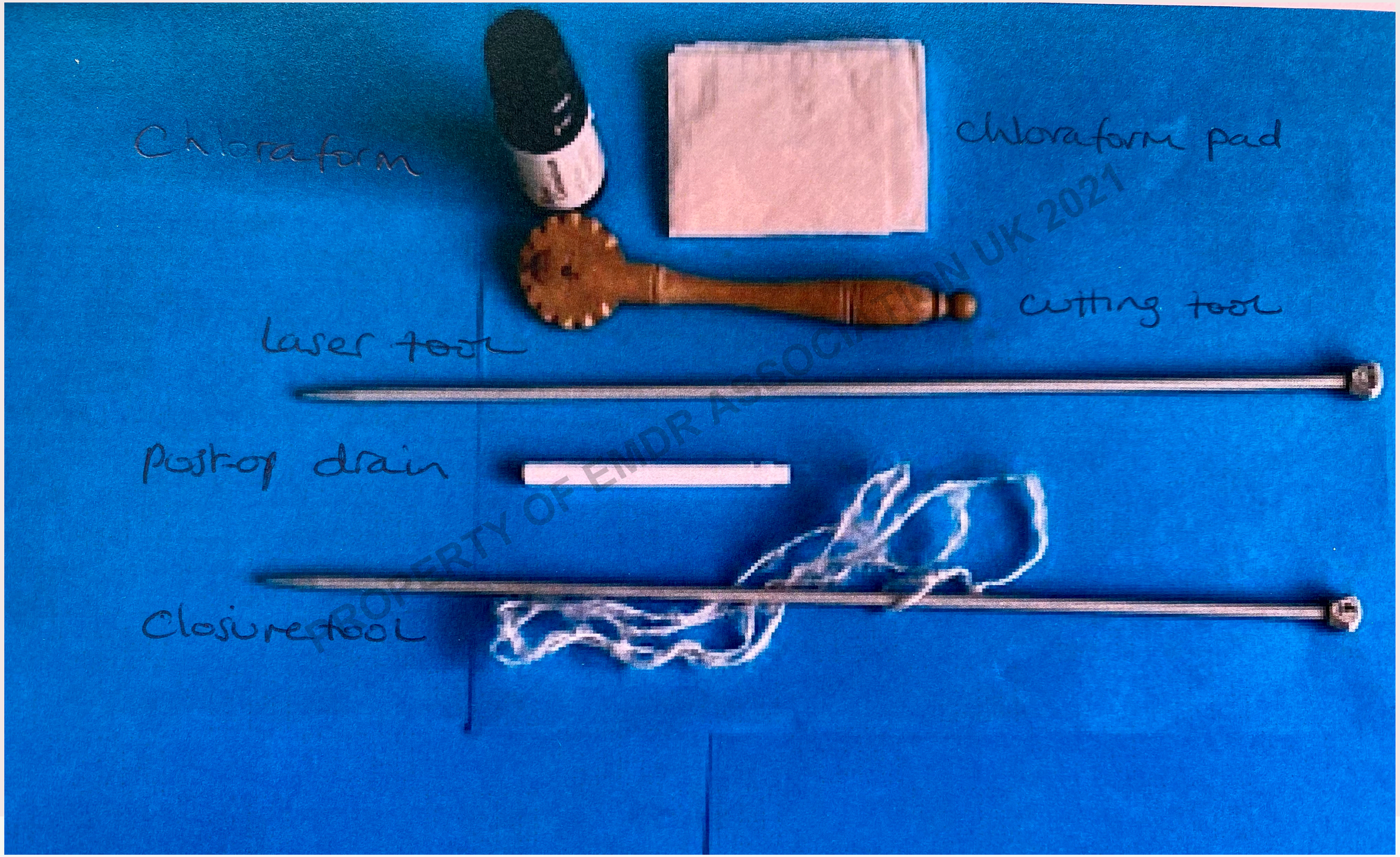
What did we do - Blood

- Blood SUDS 9/10
- Titrated storytelling on preverbal trauma including dream work after de-powering a dream image sufficiently to work on followed by standard protocol
- install “Brave”
- Rivers of blood (can’t say “blood”, used “The Thing”), reducing to puddles of blood, reducing to “nothing because there is nothing”
- Some parts work - frozen, helpless, trapped, stressed
- Some somatic work to increase awareness of facial and body sensations
- Control of image - wall, veil, zoom in and out
- SUDS 0/10, can say “blood 0/10, VOC 7/7, Bodyscan clear

- Standard Protocol on a few remaining incidents of accidents which precipitated fainting (and vomiting)

What did we do - Surgery

- SUDS lead up to hospital 2/10, waiting for surgery 4/10, surgery 8/10
- Themes “I’ll be in pain” and “I’m not safe”
- Imagery rehearsal of lead up to surgery preparation
- Adapted future template - titrated story telling with drama props and movie
- Going through every step, noting any disturbance and targeting that to 0/10 before continuing with procedure
- SUDS 0/10, VOC I am safe 7/7, bodyscan clear
- Dentist visit injection needed, no problem
- Surgery completed, walked into theatre and jumped on table. Fast recovery.
- Sibling cut self, blood, client no issues



Publication

Info on writing a case study

Journal of EMDR Practice and Research webpage
Go to “Submit an Article”
See “Author Guidelines”
“Instructions for writing a clinical practice article”
“Instructions for case study and case series articles”

Consent for publication/presentation

CONSENT FOR PUBLICATION/PRESENTATION OF CASE STUDY

Date:

Name of Service:

Name of Clinical Psychologist:

Name of Client:

I,……, agree to have an anonymised version of the therapy approach followed in sessions with myself and my child ……, reproduced as a case study for education and training purposes, such as appearing in a professional journal, other professional publications, or presented at a professional conference. I understand that ongoing professional development in the form of education, training, presentation, and publication is an integral part of working as a clinical psychologist and therapist. The information presented will be a brief outline of family history and client presentation at start of therapy, the diagnosis, the formulation (understanding), the resulting plan, and the therapeutic processes covered during sessions, which are related back to the formulation to understand the reasons for those therapeutic choices, and ends with the outcome so far.

The usual professional ethical requirements of confidentiality, privacy, and respect apply, and I understand our names, and other identifiers, such as school, or location will not be published. The publishing or presenting Clinical Psychologist will not discuss any aspects of the sessions other than anonymously, and in an ethical and respectful way as part of the dissemination of learning about the approach followed. If any safety or ethical concerns are raised, the clinical psychologist may consult with a senior colleague, to determine how to best protect the safety of the client, or other persons, from any significant risk.

Signed …… **Date ……**

Witnessed …… **Date ……..**