# Attachment therapy

## Practical examples of the Integrative Therapy for Attachment and Behaviour in persons with a visual-and-intellectual or intellectual disability

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# Preface

This book on *Attachment therapy: Practical Examples of the Integrative Therapy for Attachment and Behaviour* (ITAB) edited by Paula Sterkenburg and Veerle Andries, introduces a therapeutic approach for people who are often considered unable to benefit from a structured treatment method, i.e. persons with severe challenging behaviour and intellectual or multiple disabilities. Hereby, Attachment is key to lay the foundation for further development of the person and the application of different therapeutic options, which the person could not access before.

This book consists of two parts: First a short introduction of the theoretical background which gives important information about attachment, for example the 'Circle of Security' and behaviour therapy such as Applied Behavioural Analysis. Then the main part of this book follows, which consists of six cases that are extensively reported by different therapists who treated their clients for 9-18 months. The book ends with a summary of mixed-case examples. This allows the reader to be part of the sessions and to 'tag along' with the various obstacles and accomplishments that occur throughout the process. This appealing invitation to join such an intensive treatment progress is inspiring and offers multiple opportunities to critically reflect and enlarge one's own way of interacting with clients.

ITAB is based on the formation of a secure attachment with people with severe challenging behaviour, followed by offering successful behaviour modification. This approach can be complemented by different additional interventions, such as speech therapy or stress management, which makes it integrative, just as the name promises. Although ITAB is a time-consuming intervention it greatly contributes to quality of life and participation in the immediate and wider social environment.

And now I wish you an exciting journey together with the gifted therapists you will get to know throughout the book. Enjoy!

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# Objectives of this book

Like a house, ‘attachment’ consists of essential elements. To build a house, the foundation is laid first; a solid foundation on which the supporting beams rest. This is followed by the walls and the roof. When building a house, you cannot just lay a pile of bricks on top of each other. It usually requires thorough brickwork. If the bricks of a house are laid properly and the house is solid, it is important to insulate the house. This will ensure that the warmth of the heating cannot just slip out of the house in winter, and that the temperature in summer is pleasant (and not too warm). There are many steps that follow after the insulation of the house. The last step is the furnishing and finishing it off. In this phase, nice furniture will be selected for example. Decorating the house before the building blocks have been laid, is not very useful. The furniture could end up under the rubble if the unstable house collapses. Therefore, building a house is not something that happens overnight; a plan and a drawing are needed, it is done step by step and requires time, patience and energy. If all goes well, after all the hard and patient work, the house will be solid: a warm and cosy place where someone can relax. Moreover, it is a private and safe place, where no one can just go in and out without a key.

Developing an attachment relationship between the caregiver and the child is not something that automatically happens overnight either. Just like building a house, it requires a plan, craftsmanship, time, energy and trust. Most children develop an attachment relationship. This is a *secure* attachment relationship in which there is a sense of basic security and basic trust. In other words, a solid foundation. However, there are also many children who need more time to reach the next developmental milestone. This may be because of child factors (internal), such as a visual and/or intellectual disability and/or autism. Such child factors can hinder the development of a secure attachment relationship. Parental factors (external) also play a role in the development of an (in)secure attachment relationship. For children who have been through traumatic experiences, the development of a secure attachment relationship can be put under pressure.
A traumatic experience includes neglect, being placed into foster care, the loss of a significant other, or change of caregivers.

To a large extent, the way in which the child goes through the different steps of attachment development, determines the emotional development that follows. Some children with severe disabilities grow up with so many different caregivers, having to deal with communicative impairments and sometimes inadequate care, that they lack sufficient opportunities to develop attachment relationships. This results in insufficient basic trust in the attachment relationship, which can then lead to severe problems. Sometimes, the consequence is that adequate support from the caregiver/a significant other is no longer possible. The child's displayed behaviour can be seen as a mechanism for survival, in other words, a mechanism of self-protection.

Without intervention, these clients may continue to show symptoms of anxiety and panic. An insecure attachment relationship can have consequences reaching into adulthood. The severity of the challenging behaviour can take on such excessive proportions that it may be decided for example, that the client needs to be protected by restricting his freedom. However, freedom-restricting measures can increasingly form a barrier to 'real' pleasant contact with the child. This results in contact becoming mainly functional. What follows is the development of a vicious circle, in which the intentions of the child's/adult's behaviour are not understood well enough or the child is not given sufficient love and attention. This can lead to the regular caregiver feeling insecure and anxious, which can then make it more difficult for the caregiver to give a sensitive response the child's signals which can lead to increased isolation of the child. The key to unique opportunities for these children lies in breaking this circle.

In 2000, the Integrative Therapy for Attachment and Behaviour (ITAB) Protocol was written. The aim of the intervention is to break the vicious circle among children with severe challenging behaviour, disturbed attachment and with a visual and intellectual disability. Over the years, the protocol has been further adapted (updated versions were published in 2008, 2014 and 2020) and scientifically tested. ITAB has also been included as an intervention in various databases: Vilans (Vilans Intervention Database) and the Netherlands Youth Institute (NJI database Effective Youth Interventions). In practice ITAB has also been offered to children and adults with a severe and moderate intellectual disability (without visual impairment).

The approach of the therapy focuses on building an attachment relationship between the child and the person treating the child. When an attachment relationship has been established between the child and the person treating him, only then can the behavioural modification can start. By developing an attachment relationship, most of the child's challenging behaviour, gradually fades away. This happens because the attachment relationship becomes a buffer for stress. Research shows a significant reduction in challenging behaviour, based on observations and significant lower levels of stress, as revealed by cortisol measurements. After the behaviour modification, the therapy focuses a lot of attention on the generalisation or transfer of the treatment to the daily caregivers of the child. The reason for this is that the daily caregivers will continue to maintain and enter into deeper contact with the child. In this part of the therapy, a strong focus lies on promoting sensitive and responsive caregiving by the caregiver(s) of the child or adult with a visual-and-intellectual or intellectual disability.

This book describes ITAB therapy with practical examples. Seven therapists share their ITAB experiences.

Various terms are used in this book, which are further explained in the glossary (p. 112). The word 'client', which is frequently used, may be: a child, adolescent or adult. In addition, the word 'caregiver' is often used in combination with 'parent'. The term also refers to the person raising and the person taking care of the child. Where 'he' is mentioned, 'she' can also be read.

The value of this book is that it makes it concrete for therapists/ practitioners, parents and other interested parties what the course of an ITAB programme entails and what exactly the therapist needs to do to develop a meaningful relationship with the client. The book is a guide for professionals who are interested in applying ITAB therapy in practice. These examples provide practical outlines of the intervention, which is theoretically substantiated. This creates the opportunity to compare different therapists' approaches. This way they can gain inspiration, enter into discussions and continue to look critically and solution-focused for opportunities to improve their ITAB treatment.

# Part 1 Theory

Similar text can be found in Dutch in the Netherlands Jeugdinstituut (NJI) database Effectieve Jeugdinterventies (Effective Youth Interventions).

# 1 A brief summary of the intervention

The Integrative Therapy for Attachment and Behaviour (ITAB) is a psychotherapeutic treatment aimed at attachment and severe challenging behaviour. Certain problems include agression towards caregivers, self-harm and withdrawal behaviour. The target group for the therapy includes children, adolescents and adults with multiple disabilities: severe intellectual disabilities (and possible additional visual impairment) and severe problems with attachment and behaviour. The focus of the approach lies in developing an attachment relationship between the client and the therapist.

The ITAB protocol has also been adapted for children, adolescents and adults with a visual-and-moderate intellectual or moderate intellectual disability (ITAB-MID). The ITAB-MID protocol has already been applied in practice, but it has not yet been scientifically tested.

# 2 Target group

ITAB is intended for children from 9 months of age, adolescents and adults with a visual and/or severe intellectual disability and with severe problems with attachment and behaviour.

Indicative criteria (to be tested by a developmental psychologist):

- Children with a developmental age of at least 9 months[1], adolescents and adults with moderate intellectual disabilities (IQ < 50)[2].
- Clients with and without a visual impairment according to WHO standards.

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[1] For children and adults with a developmental age younger than 9 months see: Sterkenburg, 2012.

[2] The ITAB protocol has been developed for children, adolescents and adults with a severe intellectual disability (IQ < 35) with and without visual impairment. The ITAB-MID protocol has been developed for children, adolescents, and adults with a moderate intellectual disability (35 < IQ < 50) with and without visual impairment.

- Clients for whom previous interventions aimed at the daily caregiving and living situation have proved to be ineffective. This is the case when these earlier interventions show that the problem behaviour is still present and the score on the Severe Challenging Behaviour Consensus Protocol (CEP)[3] has not decreased.
- Clients who receive (or have a history of receiving) pathogenic care. The presence of pathogenic care is determined on the basis of file analysis and an intake interview. After the intake interview all indication and contraindication criteria are assessed. Pathogenic care is considered a (negative) form of care by the primary caregiver involving emotional or physical neglect or mistreatment and/or that the client was confronted with a frequent change of regular caregivers, as a result of which the client was unable to build up a stable attachment relationship with his caregiver. The DSM-5 describes pathogenic care as a pattern of extreme forms of inadequate care experienced by a child. This should be evident from at least one of the following characteristics:
    1. Social neglect or deprivation in which basic emotional needs for comfort, encouragement and affection are persistently neglected by adult caregivers.
    2. Persistent neglect of the child's basic physical needs/growing up in unusual environments, which severely limits the formation of selective attachment relationships.
    3. Repeated changing of the regular caregiver preventing the formation of an attachment relationship (American Psychiatric Association, 2013).
- Attachment research identifies signs of disturbed attachment behaviour or an attachment disorder. Attachment research consists of:
    - Developmental anamnesis: the client's attachment development is charted on the basis of a file study and an interview with the parents or caregivers. Indications of pathogenic care/ changes in caregivers are examined and inquiries are made about the developmental course of attachment from baby to calendar age and the caregiver's parenting style.
    - List of Behavioural Signs of Disturbed Attachment in Young Children (BSDA; Boris & Zeanah, 2005; Zeanah, Mammen &

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[3] Consensusprotocol Ernstig Probleemgedrag (CEP) (Kramer, 2001).

    Lieberman, 1993; Dekker-Van der Sande & Janssen, 2010): a score higher than 22 may indicate disturbed attachment behaviour.
  - Clinical Observation of Attachment. This structured observation is intended to elicit attachment-related behaviour from the client and to compare it in different relationships, namely with the attachment figure (parent/carer) and with an adult unknown to the client (the diagnostician). Scoring is done using the BSDA (Boris & Zeanah, 2005; Zeanah, Mammen & Lieberman, 1993; Dekker-Van der Sande & Janssen, 2010).
  - When filling in a table with the above-mentioned data as indicated in Dekker-Van der Sande & Janssen (2010) and with an average score between 22 and 33 *including* pathological care, the diagnostic results indicate disturbed attachment (Giltaij, 2017).
  - For a description of the BSDA, see also Stor and Storsbergen (2006) and Sterkenburg, Meddeler-Polman and Schrijver (2021).
  - For more information on diagnostics of problematic attachment, see: De Schipper, Sterkenburg, Giltaij, Schuengel, and Oosterman (2017) and De Wolff, Dekker-Van der Sande, Sterkenburg, and Thoomes-Vreugdenhill (2014).
- There is challenging behaviour. The presence of severe, persistent challenging behaviour is determined by means of a score of 3 or 4 (which indicates a high score) on the Severe Challenging Behaviour Consensus Protocol (in Dutch: Consensus-protocol Ernstig Probleemgedrag, CEP; Kramer, 2001). Also, at the start and end of the treatment, the Questionnaire on Development and Behaviour (in Dutch: Vragenlijst over Ontwikkeling en Gedrag, VOG; Koot & Dekker, 2001) and the Disruptive Behaviour Scale-Z (in Dutch: de Storend Gedragschaal-Z, SGZ; Kraijer & Kema, 1994) are conducted amongst parents and caregivers.
- Using a functional analysis of challenging behaviour according to the ABC model (Antecedents Behaviour Consequences) (Ellis, 1991) by the developmental psychologist, other possible causes for challenging behaviour, e.g. medical causes, were excluded.
- The intervention is also suitable and can be offered to migrants with severe intellectual disabilities. During the scientific research conducted by Sterkenburg (2008), an adopted child from Africa and a child of refugee parents from Asia participated. Similar

results were found with these children as with children of Dutch origin.
- The parent/caregiver needs support in promoting a sensitive and responsive caregiving style and in maintaining contact/relationship with the child.

**Contra-indication criteria (to be tested by a developmental psychologist):**
- The diagnosis of autism. This is excluded through differential diagnosis and by using the AUTI-R Scale (Van Berckelaer-Onnes & Hoekman, 1991).
- The client is extremely sensitive to the slightest touch (hypersensitivity to touch/tactile defence).
- There is an unstable parenting and caregiving system. This means that for a longer period of time there is not one single person with whom the client can build up an attachment relationship.
- The parent/caregiver is not interested in receiving support and does not want to follow the therapist's recommendations, which are offered and transferred in the third phase.

For treatment of clients with a visual-and-mild intellectual or mild intellectual disability, see Dekker-Van der Sande and Sterkenburg (2016).

# 3 Goal

At the end of the treatment, the client is open to contact with important others (in addition to the therapist) and due to the decrease in problem behaviour the client is more approachable.

# 4 Secondary goals for the client

The therapist decides on the secondary goals for the client and determines when the next phase of treatment will start. The challenging behaviour is scored on observation lists prior to the treatment, before the start of the behaviour therapy, as well as at the end of the treatment. The scores for challenging behaviour, using the

standardised lists and observation lists prior to treatment are then compared with the scores at the end of treatment.
*Goals per phase of ITAB*:
Phase 1: At the end of Phase 1 (attachment therapy), about four months after the start of the intervention, an attachment relationship is established between the client and the therapist. The client will then seek help, support or comfort from the therapist and will also undertake activities that might not previously have been possible.

Objectives Phase 1.1 Bonding
- After approximately five weeks, the client will be able to start or end the contact with the therapist on his own.
- At the end of this phase, the client can then re-establish contact with the therapist.
- At the end of this phase, the client moves along with the therapist.
- At the end of this phase, the client can enjoy the therapy sessions. The client shows this through a relaxed posture and by smiling.

Objectives Phase 1.2 Symbiosis
- The client can seek physical proximity with the therapist after about ten weeks, by sitting on a couch or rug, together with the therapist for example.
- After ten weeks, the client can respond to the therapist’s initiatives. This can for example take place by accepting toys offered by the therapist and playing with the toys for a while.
- At the end of this phase, the client can take the initiative to start playing together every now and then.
- Lastly, the client can maintain contact with the therapist for longer periods of time by maintaining uninterrupted contact with the therapist.

Goals Phase 1.3 Stimulation to individuation
- After about fifteen weeks, the client can take initiatives to play with toys/objects.
- At the end of this phase, the client can explore the surroundings and the toys.
- The client enjoys the proximity of the therapist (the client is smiling, has a relaxed posture, and he approaches the therapist on his own initiative).

- The client enjoys playing together and alongside the therapist, playing with toys, by accepting the therapist's toys and by handing toys to the therapist.
- At the end of this phase, the client can play alone for a while after the therapist has left the room.
- At the end of this phase, the client can easily re-establish contact with the therapist after the therapist has left the room.

Phase 2: At the end of Phase 2 (behavioural therapy), about six months after the start of the intervention, the client shows new, more desirable behaviour instead of challenging behaviour.

- After six months, the client can use verbal and non-verbal body language to tell the therapist what he or she likes and dislikes.
- The client shows less aggressive, self-injurious and withdrawn behaviour (CEP-score up to 1).

Phase 3: At the end of Phase 3 (generalisation), about ten months after the start of the intervention, the client seeks help, support or comfort from the daily caregiver or parent. Also the client participates in enjoyable activities that support further development.

# 5 Secondary goals for the parent/ caregiver

The secondary goals for the parent/caregiver are determined by the developmental psychologist linked to the team involved with the client. Setting the goals is done in collaboration with the therapist. On the basis of reports, observations and team discussions, the developmental psychologist assesses whether further training in sensory responsiveness is necessary.

Phase 3:

- At the end of the third phase, the parent/caregiver can support the child in a sensitive-responsive caregiving style. The parent/ caregiver:
    - is able to observe the client's verbal and non-verbal signals (watching and listening), e.g. they see when the client does not seem to make sense of something, resists something.

  - can recognise the client’s signals and is able to make this known to the client; ‘You are crying. I understand that since you are hungry/have a dirty nappy/are tired/are bored etc’.
  - can respond appropriately to the signals given by the client: give the client a drink or a clean nappy and give comfort.
- The parent/caregiver supports the client in exploring the environment; by helping the client and by having fun together.

# 6 Approach

ITAB is a phased individual psychotherapeutic treatment in which each phase has a specific function and is dependent on having successfully completed the previous phase. In the first phase, which lasts about four months, an attachment relationship is built up with the client (again or for the first time) through intensive contact. This phase consists of three subphases, namely: ‘bonding and making contact’ (which takes about four to six weeks), ‘symbiosis’ (which takes about five weeks) and ‘stimulation to individuation’ (which takes about five weeks). The second phase is behavioural therapy and lasts about two months. The third phase (which lasts four to six months) consists of generalisation and completion, in which parents and caregivers are involved. The duration of the phases is flexible. If the criteria/goals for each (sub-)phase are met, the step to the next (sub-)phase can be made.

The treatment consists of three one-hour sessions per week and is offered in the client’s daily environment, in a place with little ambient noise and where the client feels safe and comfortable. In consultation with the caregivers, the most low-stimulus room is found. During the treatment period of approximately one year, the primary caregivers support the client.

## 6.1 How are intellectual disabilities taken into account?

The ITAB approach considers the client's severe intellectual disability by his way of talking, by the understanding and empathy of the therapist, by using short sentences, gestures, intonation, by providing structure in the sessions so that the client can predict what is going to happen and by holding the sessions in the client's home. The approach also considers the wide age range between children and adults. This influences the degree of physical contact between the client and the caregiver. With young children, the therapist makes more physical contact (cuddling, sitting on the lap, rocking back and forth etc.). With older children/adults it is not possible or appropriate for them to sit on the therapist's lap. Rocking back and forth with older children is, for example, done while standing.

## 6.2 How are visual impairments taken into account?

The ITAB approach takes the client's visual impairment into consideration by creating an optimal environment: limiting or eliminating disturbing external sounds or noises and limiting or eliminating distracting visual stimuli. In addition, the therapist will pay extra attention to establishing contact and initiating play. It is difficult for people with a visual impairment to discover the world around them because they cannot, or can only do so to a limited extent. Therefore, the therapist will actively make contact and offer play materials. The therapist can make contact through sound and touch. For example: by articulating movements and sounds into words, by indicating that he is going to touch the other person before he touches him, by talking or making sounds when he moves away so that the client can hear where the therapist is in the room, by giving verbal explanations and by being predictable, for example by greeting and touching the person in the same way each time. Integrating rituals can be supportive in this. From the secure relationship with the therapist, the client will be challenged to respond and explore the world at his own pace.

## 6.3 Description of the phases

### Phase 1

*Phase 1.1: Bonding - making contact*
During the sessions, the therapist follows and adapts to the client's behaviour. Physical contact starts by respecting the distance at which the client feels comfortable; the client determines the physical distance. If, however, the client wants to sit on the therapist's lap, he will take the client on his lap. If the client prefers some space, the therapist will keep his distance. The distance between therapist and client is a distance at which the client feels comfortable.

The therapist will then slowly build up the physical contact. Starting with very light touching in a place where the child accepts it, for example a pat on the back, a stroke on a hand or a foot. First with the tips of the fingers and then with the whole hand. First only for a few seconds, then building up to a minute or more. The therapist names and articulates into words what he sees, what is happening and what is going to happen. The therapist speaks softly in a repetitive, melodious and questioning manner (just like talking to a baby). The therapist is very alert; he is not only talking but also listening and waiting for reactions from the client. The therapist articulates into words what he thinks the client is feeling. Gradually the client will take more initiatives. The therapist follows the client's movements (mirrors them). The use of rhythmic language and movements increases. Attention is paid to playfulness in the relationship, for example by varying the tone of the voice (loud - soft, high - low, fast - slow). During this phase the therapist will hum songs, rock back and forth with the client and follow the client in his movements. If the client walks, the therapist will walk along with him. When the client sings, the therapist sings along with him. If the client is fidgeting with the therapist's clothing, the therapist will fidget together with the client on his own clothes.

'Problem behaviour is not punished as it is the result of the client's high stress levels.' If the client scratches or tries to bite the therapist, the therapist will respond with a comforting and reassuring tone of voice by saying, for example, 'quiet, quiet', 'it's OK', 'shu-shu'. If the client walks away, he will be brought back to the room where the therapy sessions take place. This is done in a quiet tone of voice, clearly explaining what is happening.

*Phase 1.2: Symbiosis - secure attachment*

The therapist imitates and mirrors all sounds and words. He moves together with the client in the direction in which the client is expected to move. When the client has broken off contact with the therapist (for example by pushing the therapist away), the client can take more initiatives to re-establish contact with him. The client seeks to get closer to the therapist. The therapist then responds positively, providing additional encouragement and acceptance. During this phase, the therapist will sing songs and move to music together with the client. A form of playing together starts to develop (paying attention to a book together, feeling objects/materials together).

*Phase 1.3: Stimulation to individuation*

The therapist stimulates the client to express his own desires and feelings. He does this by encouraging the client's initiatives and by complying with his wishes. The goal of stimulating the expression of one's own feelings and desires is to develop an 'I' or 'ego' that will lead to positive desired behaviour. It is important to respond to wishes, such as when the client wants to listen to certain music or indicates that he wants to sit in a certain place.

### Phase 2 Behavioural therapy

This phase is aimed at learning new desired behaviours to replace the undesired behaviours that still interfere with group functioning and building relationships with daily caregivers. Examples of these undesired behaviours are pinching, punching, kicking and screaming. Together with the parents/caregivers, the therapist and the behavioural expert involved map out the situations in which the problem behaviour occurs, by analysing what precedes the problem behaviour and the consequences of the behaviour for the client (Antecedent-Behaviour-Consequent [ABC] analysis). This analysis focuses on daily situations in the client's living environment, for example during leisure time, social interaction moments or daily care. This analysis leads to a hypothesis regarding the function or meaning of the undesired behaviour and the consequences that reinforce and maintain the behaviour. The function analysis is repeated for all problem behaviours. When the origin of the problem behaviour is known, the therapist, the behavioural expert involved and the daily caregivers search for alternative/desirable behaviours with the same meaning for the client. Next, the therapist focuses on teaching these

alternative behaviours. For the reinforcement of the desired behaviour, the therapist uses social rewards by means of affectionate touches (pats and hugs), nods/smiles and compliments (with special attention to intonation). How the desired behaviour will be taught is worked out in a behavioural therapy plan. For example, for a client who cannot regulate emotions well (and is easily burnt out), the therapist can offer the client an object which he can squeeze. Every time the therapist gives the client this object and the client shows calmer behaviour, the therapist compliments him. Undesired behaviour is ignored and only stopped if the client threatens to harm himself or the therapist.
The behavioural therapy is only offered as individual treatment (without generalisation to other places/people).

### Phase 3 Generalisation and completion

The parents and daily caregivers play an important role in the generalisation, because it is important for them to connect with the client’s stage of development during the therapy. They should do this when offering play materials, during activities such as playing and moving together and other opportunities to make contact. The phasing out of psychotherapy therefore goes hand in hand with the support of the interaction between the parents and/or caregivers and the client in his daily environment.

# 7 Treatment protocol

The comprehensive treatment protocol is described in Braet and Bögels (Eds.) (2020). *Protocollaire behandelingen voor kinderen en adolescenten met psychische klachten deel 2* (pp. 767-792). Den Haag, Nederland: Boom Lemma. Chapter 18: Sterkenburg en Schuengel, Integratieve Therapie voor Gehechtheid en Gedrag.
See also a film about the ITAB treatment: ‘Attachment’ (www.bartimeus.nl).

# 8 For whom?

ITAB focuses on treating attachment problems (such as attraction and rejection, showing controlling behaviour, seeking little or no comfort from the significant other in situations of stress) and challenging behaviour (such as aggression towards caregivers, self-harm or withdrawal behaviour) in people with moderate or severe intellectual disabilities, with or without visual impairments. Behaviour which causes self-harm can take severe forms such as pinching, hitting, scratching or banging (where it can even lead to bleeding). In that case, the child's challenging behaviour is so severe that it becomes almost impossible for the person raising the child or caring for the adult (with whom the relationship is disrupted) to continue to take care of him. This concerns children and adults who often spend their time isolated from the living group in a care facility, receiving one-on-one care.

*Prevalence*
In 2018, The Netherlands Institute for Social Research (SCP) estimated that approximately 440,000 people (2.6% of the population) in the country have an intellectual disability (IQ < 70), of whom one sixth (about 70,000) have a severe intellectual disability (Woittiez et al., 2019). The prevalence of visual impairment is high among people with severe intellectual and multiple disabilities, varying from 66.7% (Van Splunder, Stilma, Bernsen, & Evenhuis, 2006) to 92% (Van den Broek, Janssen, Van Ramshorst, & Deen, 2006). Not much research has yet been done on the prevalence of people with intellectual disabilities and attachment problems. Janssen, Schuengel and Stolk (2002) describe that the risks of attachment problems in this target group are greater than for people without intellectual disabilities. The research shows that attachment problems explain a considerable part of the high prevalence of behavioural problems in people with intellectual disabilities; between 30% to 60% of all people with intellectual disabilities and an even higher prevalence among people with severe intellectual disabilities (Janssen, Schuengel & Stolk, 2002; Dekker & Koot, 2004). Research conducted on casefiles of clients that received advice from Bartiméus (2010) shows that in 60% of children with visual-and-intellectual disabilities, the problem behaviour may be attributed to attachment issues (Bartiméus Magazine, 2004, no. 2; Arentz, Sterkenburg & Stolk, 2010).

# 9 Causes

## Client factors

- *An intellectual disability*
  People with intellectual disabilities need more time to process information. They experience more difficulty in structuring verbal, non-verbal and sensory information and in distinguishing main and subsidiary issues (Kraijer & Plas, 2014; Van Nieuwenhuizen, 2012). It takes longer for them to develop object and person permanence. For people with intellectual disabilities, it is more difficult to deal adequately with stress. Because of their limited communicative and cognitive abilities or other (motor/sensory) limitations, they are not well able to seek the attachment figure or significant other for comfort and protection (Janssen, Schuengel & Stolk, 2002a, 2002b; Sterkenburg & Dyzel, 2021; Sterkenburg, Zaal, & Dekkers-Verbon, 2021). They will try to seek closeness, contact, support, comfort and reassurance from the attachment figure in a different way. People with profound intellectual disability with a developmental age of nine months can begin an attachment relationship if they are aware that persons and objects continue to exist, even when they disappear out of sight for a while. People who do not have this awareness can nevertheless show attachment behaviour and also need security and cherishing (Vandersande, Bosmans, Sterkenburg, Schuengel, Van den Noortgate, & Maes, 2020). When a person's cognitive level is lower, he is more limited in his communication and understanding. This necessitates a greater amount of sensitive responsiveness from the caregiver (Sterkenburg, 2011). An intellectual disability is therefore a risk factor for disrupted attachment (Schuengel & Janssen, 2006).

- *Visual-and-intellectual disability*
  For people with visual-and-intellectual disabilities, it is even more difficult to process information as they have greater difficulties in sensing non-verbal and visual information. They don't do it as quickly or miss out on it completely. Visual impairment hinders early contact between parent and child, so people with visual-and-intellectual disability have an increased risk of developing attachment disorders. Gunther (2004) states that children with a visual impairment miss out on eye contact, lack visual control and

visual feedback. A child with a visual impairment lacks visual information, which can be compensated by other senses in order to help develop an attachment relationship. People with visual impairment do this, for example, using auditory or tactile stimuli, or by the sense of smell. This way, these children learn to distinguish acquaintances from people unknown to them. This is more difficult than using visual functions, as children can only verify the presence and identity of their parent, when the parent is close to them. They use touch or smell, or the sound of the voice when the parent speaks or vocalises something. Because children with a visual impairment acquire these skills relatively late, they are also relatively late in developing internal representations of people and the space around them. As a result of this (and their increased dependence on the person raising them) separation anxiety and fear of strangers lasts longer and manifests itself more prominently, compared to children without visual impairment (Egan, 1979; Gringhuis, Moonen & Van Woudenberg, 1996; Jonker, Sterkenburg & Van Rensburg, 2015; Hoffman, Sterkenburg & Van Rensburg, 2017). In the case of people with visual-and-intellectual disabilities, the compensatory abilities of one are impeded by the other and vice versa (Van Duijvenboden, Pietersen, & Straus, 2018). Visually impaired people call upon their cognitive skills (such as memory and language abilities) to process information. People with intellectual disabilities however, call upon their visual skills. They learn more by observing others and less by using language. The combination of visual-and-intellectual disability does not allow for the extra use of intelligence or memory or of sight. The contact with the significant other is therefore hindered, which increases the risk of disturbed attachment (Gunther, 2004).

## Parental and environmental factors

- *Pathogenic environmental influences*
  Schuengel and Janssen (2006) point out that the pathogenic environmental influences associated with disturbed attachment such as neglect, mistreatment, abuse and early and frequent changes of primary caregivers are more common in children with intellectual disabilities (Giltaij, Sterkenburg & Schuengel, 2016). Some children with severe disabilities grow up with so many different caregivers having to deal with communicative impairments and sometimes inadequate care, that they lack sufficient opportunities to develop attachment relationships. These leads to increased stress because the client cannot connect to an attachment figure with everyday problems. This makes the child more vulnerable to the development of challenging behaviour. Aggressive behaviour can become an outlet or a distraction when tension, sadness, stress, or boredom occurs.

- *Coping problems of the parent*
  When a child is born, his parents develop expectations and ideas about their child's development and upbringing. When parents learn that their child has a visual and/or intellectual disability, they can experience this news as an intense loss. Parents may struggle with feelings of sadness, despair and guilt. It can also lead to confusion, questions and uncertainty. The diagnosis of a visual and/or intellectual disability in a child can coincide with major events such as medical complications (e.g., oxygen deficiency at birth or syndromes) and long-term hospitalisation. In addition, parents may be confronted with unsolicited advice, denial and lack of understanding from their surroundings. Parents can be thrown off balance when confronted with the diagnosis. This is followed by a coping process in order to regain balance (Van der Weck, Bos & Sterkenburg, 2021). This coping process can put pressure on the emotional availability of the parents and their sense of parental competence, as a result of which they are less able to respond sensitively to their child. The way in which parents adequately processes the diagnosis of their child's disability plays an important role in the child feeling safe and understood (De Belie & Van Hove, 2005).

- *Inadequate sensitive responsiveness/parenting skills*
  Raising a child with an intellectual disability requires a high level of awareness and sensitivity of the parents (Janssen et al., 2002a, 2002b). When visual impairment is added to intellectual disability, adequately interpreting the child's behaviour and wishes becomes even more complex (Gunther, 2004). When a person has an auditory disability in addition to the visual-and-intellectual disability, this requires the parent to learn new and specialist communication skills (Damen & Worm, 2013). Many parents are confronted with unexpected problems for which they cannot rely on their familiar ways of child rearing. Parents of children with intellectual disabilities have to learn to estimate their child's developmental age and not on the child's calendar age. Also, for children with an intellectual disability the adhesion signals may be less strong and the development of attachment may be slower (De Belie & Morisse, 2007). A visual impairment or a visual-and-auditive impairment can lead to confusing or more subtle attachment behaviour/attachment signals from the child (Gunther, 2004; Van den Broek et al., 2017).

- *Discontinuity in the attachment relationship: Out-of-home placement or long-term hospitalisation*
  When people with a visual and/or intellectual disability are placed out of the home or admitted to hospital (for a long time) without a permanent caregiver, cracks can occur in the attachment relationship between the caregiver and the child. This can cause the child a great deal of stress. With an out-of-home placement, the child must deal with different caregivers coming and going (because of a shift work schedule or staff turnover), which makes it difficult to form new attachment relationships and creates more stress for the child.

# 10 Consequences

In the absence of an intervention, these children/adults will continue to suffer from behaviour and psychiatric disorders. Also, they will benefit less from regular behavioural therapies and continue to show symptoms of distress. The severity of the problematic behaviour can be extreme and the child may have to be protected from himself. In the most severe cases, this has to be done by freedom restricting measures. For example, one of the children from a study previously mentioned (Sterkenburg, Schuengel & Janssen, 2008), had been wearing arm restraints for nine years prior to receiving treatment, to protect himself from self-harm. This meant the child had even less contact with the outside world. The child became increasingly isolated, resulting in even more severe challenging behaviour (Schuengel & Janssen, 2006).

With therapeutic interventions, the attachment relationship between the client and the significant other can develop in a positive way. This allows for valuable interaction moments, having fun, reciprocity and more relaxed contact and closeness.

# 11 Schematic representation of client- and environmental factors and ITAB goals

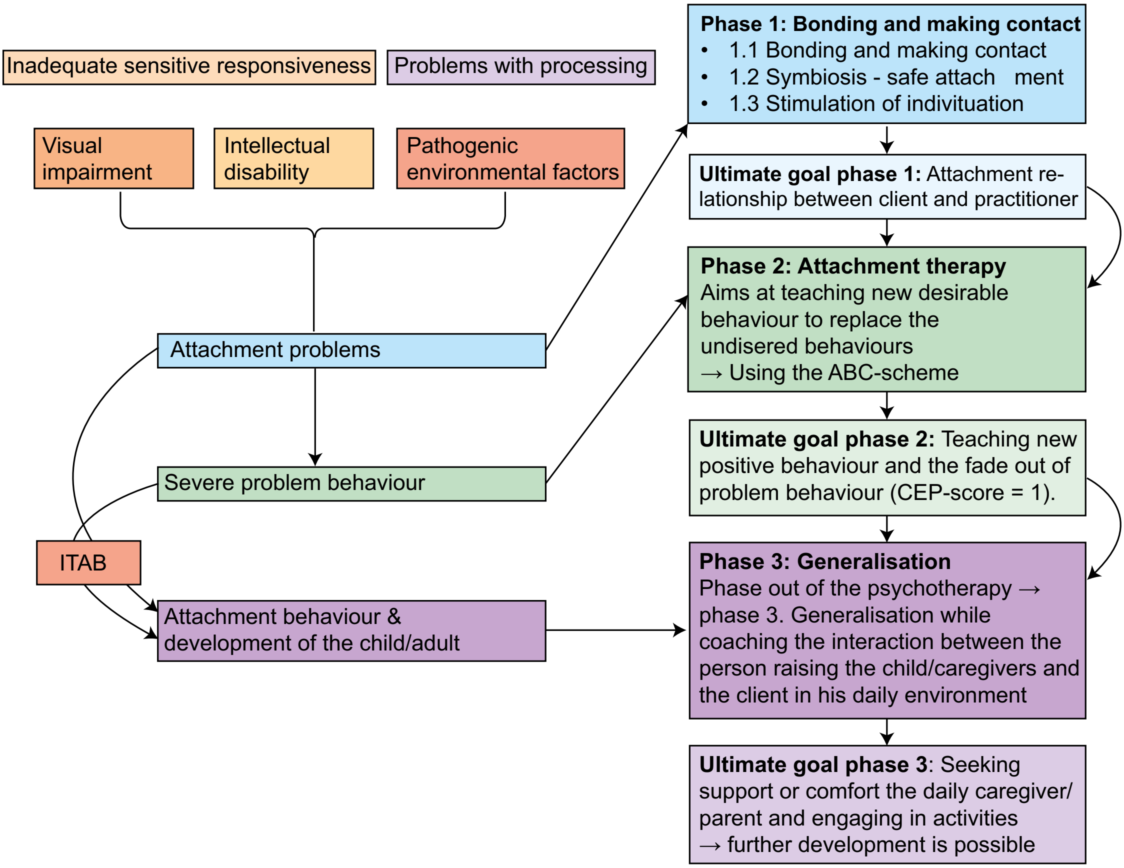


*Figure 1 Schematic representation of factors that can and cannot be influenced and the ITAB treatment goals.*

Factors that can be influenced:

→ Attachment behaviour of the client
→ Sensitive responsiveness of the parent/caregiver in the present

Factors that cannot be influenced:

→ Intellectual and/or visual impairment of the client
→ Pathogenic environmental influences from the past

# 12 Justification

Previous interventions aimed at daily assistance (including attention and behaviour therapeutic approaches) and at living situations (including competence enhancement, adjustments in the environment) proved to be ineffective in the studied target group. This called for a different approach. The children's/adults' challenging behaviour can become so severe that treatment by the parents/caregivers of the child is no longer possible. Some persons with severe disabilities grow up with so many different caregivers, having to deal with limitations in communication and sometimes inadequate care (insufficiently sensitive responsiveness of the caregivers), that they lack sufficient opportunities to develop attachment relationships. These people find it increasingly difficult to develop attachment relationships. Living in social isolation, the approval or disapproval of their caregivers hardly has any effect the children, which makes it almost impossible to steer their behavioural patterns. This means that these children/adults can no longer be influenced by social approval (encouragement) or disapproval (becoming inaccessible). This limits the possibilities of effective behaviour therapy, as in behaviour therapy it is preferable to work with social influencing (Scott & Dadds, 2009).

The ITAB's approach is intensive, because the therapist first invests in building trust with the client. This requires, in addition to the frequent number of therapy sessions, a high level of sensitive responsiveness by the therapist (Sterkenburg & Schuengel, 2010). The way in which the attachment relationship is built, forms a buffer against stress in the child (Schuengel et al., 2009; Sterkenburg & Schuengel, 2011). The intervention becomes more effective in changing and reducing challenging behaviour because of the attachment relationship (this is the aim of Phase 2 of the intervention). After developing an attachment relationship with the client, the therapist extends it to the client's broader network. This aspect also marks the ITAB's intensive approach. This is done (in Phase 3) because clients are able to maintain an attachment relationship with several people at the same time (De Schipper, Stolk, & Schuengel, 2006; Juffer, 1993) and also because in this way others can be supported in their interactions with their child. The therapist can gradually withdraw by transferring the treatment to the significant others of the client.

## What does the ITAB approach consist of?

*Developing the attachment relationship*
The ITAB uses elements from the attachment theory. Because pathogenic care is involved, the first phase of the ITAB is aimed at developing an attachment relationship. Attachment theory focuses specifically on the interaction between the development of the individual and the (parenting) relationship between the child and the significant other (Bowlby, 1984). Bowlby (1984) describes four stages in the development of an attachment relationship:

1. In the first stage of attachment, the client shows behaviour indicating a need for proximity, care or comfort without distinguishing between different people. In this stage, the child is able to focus his eyes on images, also known as configurations, that strongly resemble the human face.
2. In the second stage, the child shows behaviour indicating a need for proximity, care or comfort with one or two caregivers who provide daily care. In this phase, the child recognises the voice of the specific caregiver and reacts with a smile, a sound or movement.
3. In the third stage, the child can mainly be reassured by the closeness of the attachment figure. In this stage, in addition to passive attachment behaviour (sending out signals, raising attention), the child shows active proximity-seeking behaviour towards the significant other person (following the person when crawling, moving along). On the one hand, the child wants to explore, and on the other hand, the child wants to seek proximity to the significant other person when he is confronted with a stranger or a new environment. At the end of this stage, the child learns to make an internal representation of persons. The child also starts to differentiate between self and others (Schuengel & Janssen, 2011).
4. In the fourth stage, the child is able to take into account and empathise with the wishes and plans of the parent. The child discovers that the plans of the parent do not always correspond to his own plans. At this stage, ‘psychological proximity’ develops and the child knows that the person raising the child will always be there for him providing proximity, care, comfort and protection.

The stages outlined by Bowlby (1984) mentioned here, are followed in the first phase of the ITAB. This phase consists of forming an attachment relationship between the client and the therapist creating a buffer against stress in the client. It is possible to develop an attachment relationship between children with an intellectual disability and healthcare providers (De Schipper, Stolk, & Schuengel, 2006; Zegers, Schuengel, Van IJzendoorn, & Janssens, 2006). The therapist achieves the attachment relationship by being sensitive to the signals of the child (sensitivity) and by responding adequately to these signals (responsiveness such as offering proximity, compliments, reassurance, etc.). The therapist is able to attune well with the client by mirroring behaviour and emotions (Sterkenburg & Dyzel, 2020; 2021; Sterkenburg, Meddeler-Polman, & Schrijver, 2021). Bowlby's stages are also translated into the goal of Phase 1; namely forming an attachment relationship between the client and the therapist where the client is able to seek help, support or comfort from the therapist. In addition, Bowlby's steps are reflected in the more specific secondary goals of the ITAB described for the client. These include making contact, moving with the therapist, seeking proximity, responding to the therapist's initiatives, maintaining contact, exploring toys/objects/environment, playing by himself, refraining from play when the therapist leaves the room and re-connecting when the therapist re-enters the room.

### *Behavioural therapy*

In addition, the ITAB uses elements from social learning theory (Bandura, 1977). Social learning theory assumes that behaviour is influenced by what precedes behaviour and what follows on from it. This can be represented in the ABC scheme, in which A is for antecedent (or activating event), B stands for behaviour, and the C for the consequence of the behaviour. Specific elements of social learning theory used in the ITAB are extinction (i.e. the stopping of undesired behaviour), offering distraction, social reward, learning desired behaviour (e.g. instead of punching, teaching the child how he can indicate what he wants or needs using his hand) and competence enhancement (positive reinforcement, compliments) (Gardner et al., 2018; Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2017). These elements will be addressed during Phase 2 of the ITAB and have been translated into the goal associated with this phase, namely that at the end of this phase the child shows new desired behaviours instead of challenging behaviours. In addition, the elements of social learning theory can be found in the more specific secondary goals described for the child. These goals relate to showing less aggressive, self-injurious and/or withdrawn behaviour and to being able to indicate his own wishes (through the use of both verbal and non-verbal signals).

*Generalisation*
Phase 3 of ITAB is aimed at promoting the relationship between the client and the caregiver. From attachment theory, we know that building attachment relationships happen with more than one caregiver (Juffer, 1993). Each person is capable of internalising attachment relationships with multiple caregivers. This is also referred to as an 'attachment network'. Research by De Schipper, Stolk and Schuengel (2005) shows that professional caregivers can be attachment figures for children with intellectual disabilities who also have behavioural problems. This means that caregivers can act as a safe haven and in this way compensate for the attachment problems that people with visual-and-intellectual disabilities have previously experienced. Secure attachment interactions between the caregiver and client will enable the client to regulate his emotions more successfully in times of stress. The importance of responding sensitively on the part of the caregiver is emphasised because it is expected to strengthen secure client-to-client interactions (De Schipper, Stolk, & Schuengel, 2005). In the third phase, the therapist will work on broadening the child's network of attachment relationships.

A phased treatment is preferable because the attachment relationship regulates stress, which then gives the client the opportunity to learn new desired behaviour (Schuengel et al., 2009). In this phase, the therapist will use video recordings. In this phase the therapist uses video recordings, because research shows that discussing the interactions between the client and the parent/caregiver contributes to a better understanding by the parent/caregiver of the client's needs (Steele et al., 2014). Video feedback offers the opportunity to make signals and expressions of the child visible, which stimulates the parent/caregiver's observation skills and empathy for the client. The therapist will ask the parent/caregiver to speak on behalf of the client ('speaking for the child'). This entails him articulating the client's behaviour, emotions and expressions shown in the video, into words. In this way, parents/caregivers are encouraged to look at behaviour from the client's perspective. In addition, the sensitivity chain will be used to explain the importance of reacting appropriately to the signals the client has shown. The

sensitivity chain consists of the signal of the client ® the response of a significant other ® reactions of the client (for example: crying ® comforting the client (for example: taking the child on one's lap/ rocking) ® calmer breathing (Juffer et al., 2017). In this way, the therapist will try to strengthen the sensitivity responsiveness of the parents/caregivers of the client (as described in the secondary goals for the parent/caregiver) (VIPP-V: Platje et al., 2018) and show how undesired behaviour in the child can be reduced by means of social reward. An (additional) visual impairment requires extra sensitivity from parents/caregivers in order to properly see the person's sensory capabilities and to adequately interpret his signals. Visually impaired people miss the visual stimulation of the outside, which means they are less challenged to explore this environment. In addition, visually impaired people show more 'stereotyped' play compared to people without a visual impairment (e.g. lining up toys or rotating objects) (Van Duijvenboden, Pietersen, & Straus, 2018). Video recordings and feedback can provide insight into the client's behaviour and can support parents/caregivers to stimulate the client's development, for example to explore the outside world.
In this phase, other forms of relational contact can also be encouraged. For example, the importance of play where one follows the other will be discussed. Tools can be used to create a context in which relational play and play where one follows the other has an important role, for example by using the toolkit for parents of persons with severe intellectual disabilities (Van Wingerden, Bos & Sterkenburg, 2021) or the Barti-mat; an interactive playing mat (Dyzel, Dekkers-Verbon, Toeters & Sterkenburg, submitted).

When discussing the video recordings, the therapist will link the elements of both theories to the secondary goals formulated for the client as well as for the parent/caregiver. For a detailed description and treatment protocol for ITAB see: Sterkenburg and Schuengel (2020).

# 13 Research

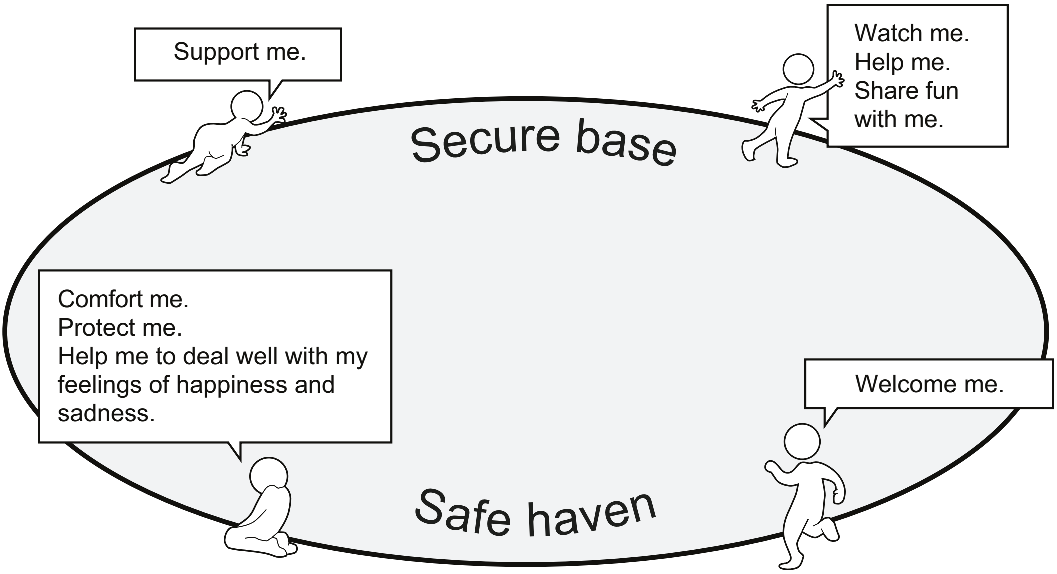
The results of the scientific research into the effects of ITAB show that the ITAB therapist is a safe haven in times of fear, stress and fatigue and a secure base for exploration (Schuengel et al., 2009; Sterkenburg & Schuengel, 2010, 2011).

To study the effectiveness of the ITAB therapy, two therapists alternated in giving the ITAB therapy and the control sessions, according to an alternating treatments design. In the first phase of treatment, the clients had alternating sessions with the attachment therapist (trying to build up an attachment relationship) and with the control therapist (simply offering positive attention to the client). During the second phase of treatment, both therapists gave the same behavioural therapy. In order to study whether the ITAB therapist formed a safe haven for the client, it was examined whether the client showed more proximity seeking behaviour towards the ITAB therapist, compared to the control session therapist during moments of stress (Schuengel et al., 2009). It was also examined whether exploratory behaviour towards the ITAB therapist shifted to the exploration of objects (Sterkenburg & Schuengel, 2010, 2011).

The study showed that the ITAB therapist evoked significantly more attachment behaviour among clients than the therapist of the control sessions. Also it became clear that clients showed significantly longer periods of active - to very active - proximity seeking behaviour. In addition, at times of high sympathetic and parasympathetic arousal, clients showed significantly longer periods of (very) active proximity seeking behaviour towards the ITAB therapist compared to the therapist of the control sessions (Schuengel et al., 2009). The ITAB therapist also acted as a secure base for clients. Clients showed more exploration towards the ITAB therapist in Phase 1.1 (Bonding) and in Phase 1.2 (Symbiosis) compared to the therapist of the control sessions. In Phase 1.3 (Stimulation to Individuation) clients showed more exploration of objects (Sterkenburg & Schuengel, 2010, 2011). This was also visible in the phase of behaviour therapy; a stressful phase, in which situations are created that are difficult for the client and can therefore trigger challenging behaviour. The ITAB therapist and the therapist of the control group carried out the same behaviour therapy protocol, which was composed for each client. Psychophysiological measurements during the sessions, based on heart rate measurements, showed that the behavioural therapy with the ITAB therapist was considerably less stressful compared to control therapy sessions. In addition, it was found that challenging behaviour among all clients had decreased by the end of the course of treatment. This was the case both during the therapy sessions and in the daily living environment. This positive effect was found both in the initial and in the final diagnoses based on the Challenging Behaviour Consensus Protocol (CEP) (Kramer, 2001), the Disruptive Behavioural Scale (in Dutch: Storend Gedragschaal-Z SGZ, Kraijer & Kema, 1994), daily observation lists and the independent observations of the therapy sessions. In the first phase of the therapy it had already become clear that the challenging behaviour had considerably decreased, and this continued in the second and third phase of the treatment. As the clients showed significantly more desired behaviour during the behaviour therapy sessions conducted by the ITAB therapist compared to the sessions of the control therapist, the ITAB therapy proved to be more effective than the control sessions. Based on these findings, it is concluded that the ITAB therapy was more effective for these clients than only offering behavioural therapy. The person who held the control session, was a therapist with whom the client was familiar but with whom he had not built up an attachment relationship (Sterkenburg, Schuengel & Janssen, 2008).

# 14 ‘Circle of Security’

The ‘Circle of Security’ was developed by Marvin, Cooper, Hoffman and Powell (2002) and can be used to describe the process of bonding.



*Circle of Security*
*Based on: The Circle of Security: What children need from their parents (Marvin, Cooper, Hoffman & Powell, 2002; Powell, Cooper, Hoffman & Marvin, 2016).*

A safe haven means that someone can fall back on a significant other who is emotionally available and who can offer comfort and protection. Such a sensitive responsive attachment figure will contribute to emotion regulation (Sterkenburg, Zaal & Dekkers-Verbon, 2021). A secure base offers a person space to explore, to discover the environment and to be supported by the significant other/caregiver. This supports the exploration by the person. The accompanying quote is: ‘I need you to... support my exploration.’

Learning and discovering happens in fits and starts. When someone is scared, or in need of reassurance/proximity, the person can seek comfort from the significant other (safe haven). Then, after comfort and protection have been provided, the person can continue to explore the environment from the secure base. The secure base and the safe haven are interdependent. The person feels safe where there is a balance between the secure base function and the safe haven function (Powell et al., 2016).

# 15 Process evaluation of the ITAB intervention

There has been an annual Basic Course Attachment Therapy since 2006 within the RINO group (a post-master training centre in Utrecht, the Netherlands) since when eleven developmental psychologists have so far also followed the Attachment Therapy practical course. The practical course consists of twelve meetings of three hours maximum each held monthly. The meetings are held in groups of two or three course participants or individually (one hour per meeting). Participants on the course learn to carry out ITAB-therapy independently, under supervision. An anonymous link to a digital questionnaire in Qualtrics was sent by e-mail to all course participants who up to 2019 received supervision. Six of the eleven ITAB therapists completed the questionnaire. Of these, four (66.7%) started giving the ITAB treatment three years ago, one respondent (16.7%) started two years ago and another respondent started more recently.

Answers to the digital questionnaire show that the treatment protocol as currently developed and tested can be used in practice and does not need much improvement. Almost all respondents succeeded in adhering to the treatment protocol, although there are a few pitfalls. One suggestion for improving the protocol is to make it more practically applicable to people with motor limitations, for example, those who are wheelchair bound. In addition, not everyone manages to complete the therapy within one year. This aspect could be taken into account more. As the ITAB is intensive (three sessions per week) and the period for treatment is often extended, the rate at which clients pass through is not very high. Respondents clearly indicated a demand for the therapy and that there are clients waiting for treatment. More therapists could potentially be trained in the future, to provide more ITAB therapy. Almost all respondents go through all phases of the therapy well. One respondent was not able to go through the second or third phase but went through all the sub phases of the first phase thoroughly. More attention could be given to the behavioural therapy and generalisation phases and to general advice for carers/parents after the intervention. This, as half of the clients with severe multiple intellectual disabilities return for treatment because, for example, the implementation was ineffective or weakened due to team changes.

# 16 ITAB in practice

The process evaluation shows that tools for the behavioural therapy and for generalisation phases can be added to the protocol. The experiences of the respondents and other ITAB therapists can play an important role in these phases. It was therefore decided to combine the different experiences of the seven ITAB therapists so that they could provide a more comprehensive understanding for therapists going forward.

# 17 Treatment of children and adults with visual and intellectual disabilities

In Sterkenburg and Braakman (2019) general points of attention are described for the treatment of children and adults with a visual and intellectual disability. These points are:

a. It is of utmost importance to pay attention to a safe therapy setting; if it is possible, it is important that the client indicates where he would like to sit (with back to the window or with a more filtered light).
b. Pay attention to the furniture including rounded table corners.
c. Pay attention to the prevention of background noise.
d. Ensure a clear transfer of knowledge and information to the client, parents and caregivers.
e. Note the use of complementary colours and large pictograms.

f. In the case of exercises, pay attention to the length of the exercise and the use of understandable language.
g. Make sure that parents and caregivers are involved in treatment as they can help interpret signs or behaviour related to visual impairment.

Within ITAB, the following points can be further considered:
Ensure predictability by explaining where you are going to sit, what you are going to do and what is happening in the environment. Repetition of explanations may also be important so that the client has a good understanding of what is going to happen and/or what is expected of him. Visually impaired people need more time to process information: give the client the time he needs and remember to slow down your pace. Also mention the client's name when establishing contact, as by mentioning his name he will know that you are talking to him.
In addition to articulating into words what happens in the environment, articulate the client's feelings and behaviours as well. We call this 'mirroring of emotions and behaviour' (Sterkenburg et al., 2021). For clients with a visual impairment, pay even more attention to the tone of your voice and the rhythm of your spoken words. Try to speak calmly, so that you can calm the client who may be under a lot of stress. Repeat your message. For example: 'Isn't this exciting, we're just sitting on the couch together. Isn't it exciting? I'm just sitting on the couch with you; so, let's take a breath together while we sit on the couch together.'
When toys or objects are used during treatment, place them in a fixed place. The client can then, over time, find them himself.

# Part 2 Practice

# Introduction

Part 1 contains a detailed description of the scientific basis of ITAB and a description of the treatment. The treatment is in line with the mediating methods (Dozier, Highley, Albus, & Nutter, 2002; Došen, 1990; Došen & Day, 2001; Fisher, Ellis, & Chamberlain, 1999).
It integrates the building of a relationship (attachment theory) with the learning of new desired behaviour (learning theory). The treatment protocol for the Integrative Therapy Attachment Behaviour (ITAB) is also described extensively in Sterkenburg and Schuengel (2020) and scientific research has been conducted into the effects of and underlying mechanisms for change (Schuengel, De Schipper, & Sterkenburg, 2003; Sterkenburg, Janssen, & Schuengel, 2008, Sterkenburg, Schuengel, & Janssen, 2008; Schuengel, Sterkenburg, Jeczynski, Janssen, & Jongbloed, 2009).
Part 2 describes several practical cases explained by the therapist and is written in the first person. Those directly involved have given their consent to the publication of the cases, which were anonymised.

First there is a brief impression of the person and the problems and preparation for the ITAB therapy. Next there is a description of the course of the ITAB treatment and its phases and sub-phases:
Phase 1: Attachment Therapy
    Phase 1.1. Bonding - Making contact
    Phase 1.2 Symbiosis
    Phase 1.3 Stimulation to Individuation
Phase 2: Behavioural therapy
Phase 3: Generalisation

Then, the completion of the case is discussed, followed by the feedback given by client's relatives. At the end of the case, the therapist introduces himself.

# 1 Case Eva

**A young adult woman with visual-and-motor impairment and severe intellectual disability**

*Margot Vos*

## 1 Introduction to the case

### 1.1 Intake and assessment

Eva is a young adult woman with visual-and-motor impairment and severe intellectual disability. It has not been possible to identify the cause of her disabilities. Although the cause was thought to be a syndrome based on multiple birth deficits, based on genetic research no syndrome could be found. Shortly after birth she underwent surgery for a heart defect. She is partially sighted and has some complex eye defects for which she had surgery at a young age. Eva hears well and understands simple sentences. Although she doesn't speak, she is able to communicate through non-verbal behaviour. She busies herself with brightly coloured photographs in plastic and magazines. She waives them in a fan, throws them around and rustles them. There is however a build-up of tension and severe self-harm. This self-harm has led to physical and functional damage. Caregivers experience Eva's severe inability to act due to fear. Previous research of the client using the Consensus Severe Problem Behaviour (*Consensusprotocol Ernstig Probleemgedrag,* CEP) indicated a very severe problem (score 3).

In 2015, assessment has been carried out questioning: Is there disturbed attachment and if so, what treatment is recommended? The diagnosis is based on a Dutch screenings instrument List of Signals of Disturbed Attachment Behaviour (LSDB: Boris & Zeanah, 2005, Zeanah, Mammen & Lieberman, 1993).[4] Both parents and the personal caregiver were interviewed. Also, a dossier analysis was conducted. Secondly, assessment of her attachment behaviour was carried out. This was done using the Clinical Observation of Attachment (COA). The results of this COA were included in the

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[4] List of Behavioural Signs of Disturbed Attachment in Young Children (BSDA), Boris & Zeanah (2005).

assessment of the LSDB. Assessment was done as described in Dekker-Van der Sande & Janssen, 2010).

The average score of 24.1 on the LSDB indicates that there is a probable disturbed attachment. In 2016 Eva was registered for ITAB via the counselling point of the institution of her daytime activities. There was a waiting list. Treatment began in the spring of 2017 and continued until July 2019.

### 1.2 Preparation ITAB

Eva lives at home with her parents. During the day, she visits the day care centre connected to a residential facility. Eva has after-school care in one of the living groups. In the near future she will also get a place to stay overnight in this living group. The ITAB will be given at the day care centre, in close collaboration with its team.

Together with the personal caregiver, I discussed where and at what times the therapy should be given. Initially we opted for a fixed time on fixed days: every Monday - Wednesday - Friday morning. But it was difficult to decide on a fixed place; the place had to be familiar, in a quiet environment and there had to be a possibility for filming. At first, we ended up in a guest room on the ground floor. However, during the first appointment it became clear that in this, for her unfamiliar, room Eva felt insecure. That is why we moved the therapy to Eva's own room at the day care centre where she did accept me. The disadvantage however was that I could not film in her room. Therefore, after the first contact was made, we moved the therapy to the, for her familiar, gymnasium.

The personal caregiver has informed the parents and scheduled an interview for the intake. During this interview, the ITAB's objectives were explained, expectations were discussed, and agreements were made about working methods, mutual communication, permission to inspect Eva's personal file and the use of film material. We agreed that I would report back on each session, both to the parents and to the personal caregiver and perform a periodically interim evaluation. In addition, I would have a brief feedback with the team at the day care centre after every session.

# 2 ITAB therapy

## 2.1 Phase 1: Attachment Therapy

*Phase 1.1: Bonding - Making contact*

Initially I had chosen a space outside the day centre for the sessions. Eva started to hit herself in the face and cry in the room. She lay down alternately on the bed and on the pillow. I followed her, but she didn’t let me comfort her. Unfortunately she managed to hit herself so hard that her nose began to bleed. I took her to the bathroom and wiped her hands and face with a wet flannel. I repeated this a few times because it seemed to calm her down. Then Eva walked to the door. When I went to stand next to her, she wrapped her arm around my shoulders and pulled on the doorknob. I interpreted this as a request to leave the room and opened the door. I articulated this into words and together we walked back to the day care centre where we stayed in her room for a while. Eva accepted my presence. Because of that first experience I stayed in her room for the two sessions that followed and she accepted my presence. When she left the room, I followed her. When she went back to her room, I followed her.

About two weeks after the first contact had been made, I started holding the sessions in the gym. Initially Eva didn’t join me directly when I invited her: she hit herself in the face or walked away from me. It turned out to be important to wait until she had made up her mind whether or not to join me, and clearly articulated into words what we were going to do. This became a fixed ritual; I stayed with her with a plastic box of photos and magazines until she reacted. Then I could invite her to come with me. After some time Eva reacted directly to my presence by standing up and taking my hand. During the whole therapy period pointing to the plastic box remained the signal that we were going to do something together.

In the gym we also initially followed a fixed ritual in which the environment remained the same, as well as the course of the session. After some time, she no longer needed this ritual and variations in the ritual could be made. Initially, Eva would determine the length of every session by staying in the gym or walking to the exit door (after either a short or longer period of time). I interpreted this as her wanting to go back to the group living room and followed her into it. Gradually Eva stayed for longer periods of time. On the one hand because she wanted to and on the other hand because I tried to stretch the moment when she stood at the door (see Symbiosis). After some time, Eva was able to stay until I would give the signal to stop. For this we also developed a ritual; in order to stand up, Eva needed my help; I sat down on my knees and Eva would get up using my shoulders for support. In later sessions the ritual was not needed; the announcement that ‘we are finished, and we are going to clean up’ became sufficiently recognisable.

*Phase 1.2: Symbiosis*

In the gym we worked on a large seat cushion. Eva would sit down and look for some pictures or a magazine from the plastic box, which I always made sure to place within arm’s reach of her so she could find them easily by herself. She would then lie down and wave the pictures in a fan. I sat down closely beside her. In the first few months Eva sought a lot of physical contact: she crossed her legs over mine, wrapped her arm around me, or rolled herself up against me. I joined in by putting my arm around her shoulders, rocking, singing and massaging her shoulders or upper arms.

In those moments she could pull my hair very hard. Her mother described it as ‘a token of love’. I understood it in the same way: when she pulled my hair, I put my hand over hers, joined in the movement and articulated her emotions into words. In this way I followed the client’s initiative to make contact, however, making sure her pulling my hair did not hurt me. By following her movements, she relaxed and subsequently let go again of my hair. She stopped pulling my hair in due course, but that may also have had something to do with the fact that our contact became less physical over time.

I mirrored her play with the photos and the magazines. In the meantime, I tidied her photos when she had thrown them all over the room. After a while I made variations; Eva threw photos away and I threw them back again. Or I gave her photos which she then threw away. We could either wave or browse through a magazine together, or we could 'nuzzle' (sometimes literally: reducing the viewing distance because of her visual impairment!) in it together, saying that it smelt good, or I would tell in a soft voice everything that could be seen on the page.

Eva soon started asking me things by tapping me, by pushing my hand in a certain direction or by taking me to a certain place. I always reacted positively to this, as result of which her number of questions increased. She also took more initiative in our activities during the sessions. Subsequently, I was able to respond in an in-tune/out-of-tune manner. Whenever questions came up I didn't directly seek to answer them; I waited a while. If Eva would stand at the door to stop the session, for example, I would walk around the gym with her and sit down with her somewhere else to continue playing. When she nudged my arm I would wait for a moment until she indicated more clearly what she wanted.

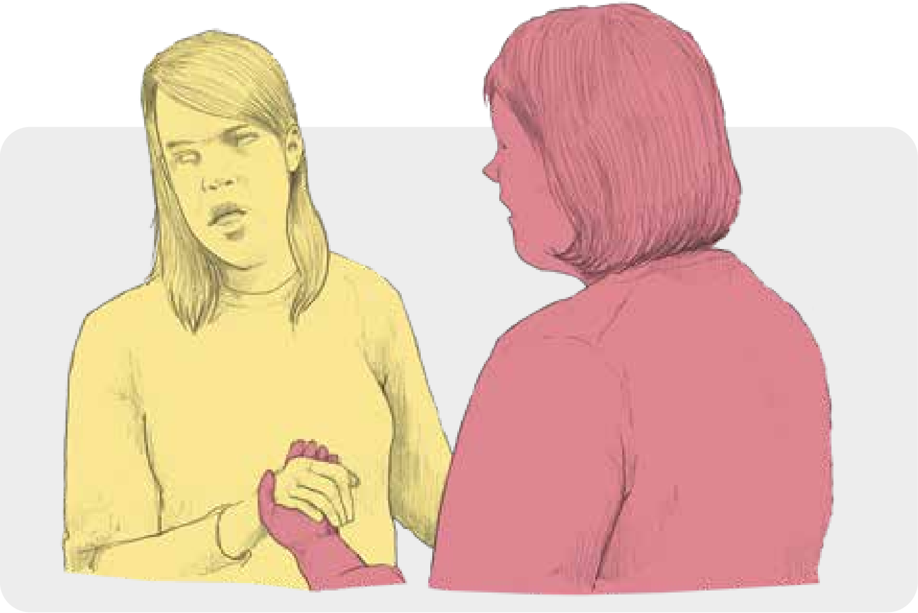
There were regular moments of unrest and self-harm. I would then try to soothe and comfort her after which she would quickly stop self-harming. It was more difficult to soothe her grief. Eva could lie against me for up to twenty minutes and cry. After a few months, these periods of restlessness and crying became shorter. Eva allowed herself to be comforted more quickly, after which she was able to continue to play. Later the restlessness and self-harm occurred only occasionally.

### *Phase 1.3: Stimulation to individuation*

After some time I expanded our game with photos and magazines - taking into account her visual impairment - with other play materials, such as music boxes, music books, prickly balls, balls with lighting.
I would suddenly throw a ball between the photos. We would also bring 'musical books' with us in the plastic box. Eva loved the sounds coming from the books, keeping the books close to her ear.
She introduced a kind of Peek-a-boo game herself. In the group she could enjoy pulling something over her head, such as her coat, or a blanket. I also brought a blanket to the sessions. When she pulled it

over her head, I called: ‘Where are you now? I can’t see you anymore!’ And when she took the blanket off her head, I said ‘Aaah, there you are again!’ Eva loved this game: she pulled the blanket over her head time after time again, then waited until I called: ‘Where are you now?’, after which she laughed. In later sessions, she was also able to shake her blanket and then pull it away!

Turn-taking also turned out to be a fun game. For example: when Eva stamped her foot on the ground, I did the same. And after a couple of times we would switch roles: Eva would hit the ground with her heel, while I waited and did the same and repeated this. She liked to play with the activity centre with which she could make all kinds of sounds. She really enjoyed hitting the ground with it, after which I said ‘Boom’. She then repeated her action and had a lot of fun doing so.



Eva needed a little more time getting used to bigger activities. There was a large bouncy (air) cushion in the gym. The first time I showed her the cushion, she was not interested. I then again blew up the cushion the next few times, after which (her curiosity overtook her and) she then became interested. She went out on her own to see what it was and climbed very carefully to the outermost point. In my presence and with her pictures and magazines nearby, she dared to go a bit further each time until she finally lay completely on it! One time when I hadn't blown up the cushion it happened that she herself asked me to blow it up. She did this by taking me to the (flat) air cushion and pushing my hand towards it. I saw the same pattern when using the magic table[5] in the hall. The first couple of times I had set everything up and brought Eva (with a plastic container with photos and magazines) with me. Eva sat down with me at the table and we mainly played with photos. The following times, the pictures on the table and the accompanying sounds were more noticeable. She could lie down with her nose on the table or look in the direction of something. She laughed at the different sounds and music. After a few times Eva was able to take me to the magic table as soon as I came in. Here too, the plastic container and its contents remained important. If we forgot it once, she would go back especially for it!

## 2.2 Phase 2 Behavioural therapy

After the attachment therapy phase, much of the restless behaviour had already disappeared. What returned regularly, however, was restless behaviour in the afternoon. This behaviour manifested itself as follows: Eva was physically restless, searching, standing at the door or window. She could cry and self-harm and did not accept any attention or distractions. Caregivers felt very unsure about their caregiving; at such moments they could barely make contact with her. A plan was made to make an ABC analysis but for various reasons the caregivers did not succeed in completing it. That's why I moved my sessions with Eva to the afternoon. I could then see for myself what was happening and try out what Eva needed to get out of such a mood. For a thorough ABC analysis I had a separate consultation session with her caregivers and discussed her day programme concerning her restless behaviour in the afternoon.

With regard to the afternoon sessions, I found Eva in contrasting moods. They ranged from relaxed to very restless. The course of the sessions depended on her mood at the time. But each time she was comforted by me and came back to play and have fun. From this I

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[5] The Tovertafel ('The Magic Table') is a little box containing a projector, sensors, speakers and a processer that together project different games on a table. Colourful objects respond to hand and arm movements.

learned that despite the later time of day, she was still able to accept comfort and help from a person she trusted.

Interviews with the caregivers showed that there was a lot of unrest and uncertainty during the day. There was little continuity in the staffing and in the daytime programme. As a result, Eva lacked structure and a balanced distribution of activities throughout the day. As a result, she collapsed after lunch, was no longer able to commit herself to activities and had a greater need for a person she trusted. Targeted action was taken on these points; a permanent team was formed, comprising two permanent employees at the day care centre who were supported by two permanent employees from the home. In the daily programme, the work and activities are concretely set out for each part of the day. The caregivers follow this daily programme.

### 2.3 Phase 3 Generalisation and Completion

In the conversations with the caregivers it also appeared that they did not know how to connect with Eva. When she was relaxed they were afraid to ‘disturb’ her. Their experience was that if they sought contact with Eva she would ask for something that they had to refuse which would then be another reason for Eva to self-harm. When she was tense and restless, they did not know how to act. The analysis behind it was that at such a moment she was over-excited and needed the peace and quiet of ‘being alone in her room’. Therefore this ‘isolation’ was offered to her. But, because of this, the contact outside the moments of care was reduced to a minimum.

Because of the uncertainty about contact with Eva, caregivers were less able to be the trusted persons she needed. It was therefore decided to focus the further completion of the therapy on promoting contact between the caregivers and Eva. To this end, the contact coaching method Five Elephants, (*Vijf Olifanten*, De Geeter & Munsterman, 2017) was used. All four team members followed this contact coaching. After an introduction to the concept of Contact, they were coached on their contact with Eva using their own video images. In order to build a bond of trust with Eva it was agreed that they would use this knowledge and learning points on a daily basis in their contact. Since then such contact moments are included in the newly set up day programme.

This increases Eva's confidence in me first and foremost, to confide in her caregivers. The bond she builds with her caregivers in this way forms a buffer against daily stress and gives her room for exploration.

## 3 Completion

Eva has learnt to build a relationship of trust with a 'trusted other'. Adapting to her pace and using recognisable rituals has helped her do this. With the strengthening of the bonds she also appears to be able to let go of these rituals. The bonds she now builds with her caregivers form a buffer against daily stress and give her room for exploration. With her trusted caregivers she can now have fun, ask for help and comfort and accept new activities. Eva can accept a temporary absence of the trusted other. When reunited, she picks up where she left off. She has a sense of role-playing (taking turns) but cannot empathise with the other. Because of this, her way of asking questions sometimes seems somewhat insistent, without her meaning so. She has her own familiar materials such as photographs and magazines. These are important supports to her. With these objects close by, she dares to take on new challenges.

The ITAB's goal of reducing stress build-up and self-harm has largely been achieved. Fear of acting on the part of caregivers has been solved to a large extent by contact coaching. Tension build-up still occurs when the situation is unclear, when caregivers who are important to her are absent or when she is physically unwell. The presence of at least one trusted caregiver and a familiar day programme remain a prerequisite for her to feel comfortable and safe. Caregivers will always have to work on their contacts with Eva. New caregivers will need help in this by, among other things, following the 'relationship development plan' that has been developed by the team.

In my opinion, the ITAB is a very effective way to connect with a client and gain the client's trust. During the intensive individual contact, trust grows quickly, which can lead to attachment. My experience is that it is difficult to transfer this to the caregivers in the daily work environment. This deserves attention. It is also important to transfer knowledge about the treatment and about the necessary extra contextual adaptations - taking into account her visual impairment.

Eva quickly learned to put her trust in her therapist. To extend that into trust in her caregivers proved much more difficult. That appears generally to be the case for all parties. As this case makes clear, it first appeared necessary to work on the contact that caregivers had with Eva. In this situation, there was very little real contact between Eva and her caregivers. There were also prejudices and (misplaced) beliefs in the vision of Eva. As a therapist, it is important to pay a lot of attention to this. And it should be part of the therapy to do something about this. In any case, I took it as my task to help caregivers get in to touch with Eva and review their opinions of her.

The practice itself can also make it difficult for all parties (ITAB therapist, client, caregivers, relatives) to generalise an established relationship of trust between ITAB therapist and client to the caregivers. Pressures of work, varying levels of staffing and dilemmas (other clients) can make this very difficult. The practice must meet important conditions in order for the generalisation to have a chance of succeeding. I am thinking of a stable team, clarity and predictability in the day-to-day programme and possibilities to deal with people and options in a flexible way. Here too, it is important to talk with the team a lot, to empathise with their situation and the way they experience it. The support of the management is also important here. I myself have experienced a lot of support from the facility's location manager. And now she also gives the team a lot of support in this.

## 4 Reporting to the client's relatives

After the advice 'to start with ITAB' was given, Eva's parents had to wait quite some time before the therapy could begin (because of organisational reasons). The parents found this difficult. However, the waiting time did not affect the cooperation etween them and me. Clear agreements have been made about the communication between parents - myself - personal caregiver and the team. As a result, all parties were kept well informed on progress throughout the process.

Unrest, tension building and self-harm are identified both by parents and the day care team as the main bottlenecks in the therapy. The parents did not know in advance what to expect from the therapy. They hoped that it would help their daughter to live with less tension.

The team hoped that the therapy could reduce their fear of intervention.

Difficult situations were for example when the parents wanted me to react in a specific way to the behaviour of Eva when in my opinion, based on the theoretical background of the ITAB, it would be better to act in another way. For example, her parents wanted me to ‘forbid’ hair pulling while I ‘followed her’ to maintain contact. We (Eva’s parents and I) have always been able to discuss this very well. On the other hand they sometimes had tips or rituals that I could fit very well into the therapy. I talked regularly with the caregivers about how they could shape the contact with Eva in such a way that they could build a bond together. A lot of time was spent on this. It was difficult for the staff members, however, to free themselves from certain ideas. ‘Following the child’s behaviour’ for example, was seen as ‘always giving someone her own way and that is not possible’. They mentioned: ‘There are more clients. I can’t spend all the time on this one person’. And: ‘We don’t have time for that, we always have shortages’. These opinions were difficult to change. An introduction of the ‘Circle of Security’ did give them insight into how Eva’s behaviour can be read, in addition to the contact method *Vijf Olifanten* (Five Elephants). In the discussion of the concluding treatment report, parents and caregivers were able to agree.

## 5 Who is the therapist?

**Margot Vos**

My career in care began in psychiatry where I completed a Bachelor of Science in Nursing. I came into contact with developmental psychology via a trainee of the programme. I registered for the course developmental psychology at Nijmegen University in the Netherlands after which I completed my Masters degree. I then stayed at home for a number of years for my children who were born at that time.

As my children grew older, I started working part-time as a caregiver in the care of people with intellectual disabilities. After a number of years, I took up developmental psychology again at Ons Tweede Thuis. I followed postgraduate education including the Basic Course on Attachment therapy to become an ITAB therapist. After a supervision course, I was able to give therapy within the organisation which I found enormously satisfying and hopeful as I described in this case.

# 2 Case Jeffrey

**A nine-year-old boy with severe intellectual and multiple disabilities**

***Renate Hilgers***

## 1 Introduction to the case

### 1.1 Intake and assessment

*Registration*

Close colleagues of mine, developmental psychologists within the healthcare organisation, knew that I had followed the ITAB therapist course and that I was working on a first course of treatment that was going well. Therefore, in 2016 a colleague asked me whether ITAB might be suitable for Jeffrey; at that time a 9-year-old boy with severe intellectual and multiple disabilities with whom she was involved. Jeffrey had been living at the care organisation’s residential facility since 2014. Prior to that he had lived at a different location within the same care organisation (2012 to 2014). Jeffrey regularly showed a lot of stress - daily activities could lead to challenging behaviour. He would bite his hand hard for example. Also, he would vomit regularly and his weight was worrisome. He has loving parents with whom he has good contact. He was an accessible little boy: he would immediately be fine with everyone when they would reach out to him. According to his father ‘Jeffrey is a people person’.

Jeffrey has a very rare syndrome: Developmental Delay Epilepsy Neonatal Diabetes (DEND-syndrome). He spent the first year of his life in hospital where he underwent many medical examinations. In the following years he was also hospitalised many times. After birth, he was admitted to a hospice where he spent four years. Therefore, he had never lived with his parents. When he was growing up, he met a lot of different people, not all of whom were focused on his psychological needs by any means. He had limited experiences of his body helping him fulfilling his needs or of being able to exert influence by himself. Positive developments became visible however, due to intensive extra care, support from various disciplines, a stable place to live and spend his daytime activities and because of tthe care from his parents. One such development was that there was less stress when he had to change posture or when he was being transported to the day care centre. However, there were also concerns that challenging behaviour would increase in the future. This information led to further diagnostics in the area of attachment, and a disturbed attachment was suspected.

*Diagnostics*
The scoring List of Behavioural Signs of Disturbed Attachment in Young Children (Boris & Zeanah, 2005, Zeanah, Mammen & Lieberman, 1993) was used for diagnosis. The items were scored in various ways; Jeffrey's personal file was screened for signs of disturbed attachment and interviews were conducted with the parents and with a trusted caregiver. The observation test 'Clinical Observation of Attachment' (COA) was completed together with Jeffrey's mother as well as with someone who did not know him. Two developmental psychologists scored the video recording of COA using the List of Behavioural Signs of Disturbed Attachment in Young Children (Boris & Zeanah, 2005; Zeanah, Mammen & Lieberman, 1993). This was done in accordance with the procedure set out in Dekker-Van der Sande and Janssen (2010). There was a mean score of 23 for disturbed attachment behaviour.

### 1.2 Preparation ITAB

In the previous course of therapy I found it useful to conduct the sessions at both the home residence and at the location of the daytime activities so that I could include both caregiving teams in the process. Therefore, I held the sessions of about one hour in Jeffrey's own (bed)room twice a week and once a week in a fixed room at Jeffrey's daytime activity centre. The latter was not easy due to the lack of space. Therefore, a fixed room was reserved. Some preparation was needed here, such as bringing a beanbag and pillows to the room. For Jeffrey it was necessary to be able to get out of his wheelchair. During the sessions in his own room, everything was at hand. Another important condition was to have as little disturbance from ambient noise as possible in order for us to be able to focus fully on each other. Initially I had the door of Jeffrey's room opened slightly so that the caregivers could peak around the corner. However, Jeffrey would become too distracted when he heard sounds in the hallway. Later in the last phase of treatment, he wasn't as easily distracted and I held the sessions in the living room and in the group room of the daytime activity centre.

I always visited the group first to hear how Jeffrey was doing and to see what I should take into account such as: a busy day for him, or if he just had a meal or was vomiting. First, I made contact with Jeffrey in the group and then I took him to the room. During my first course of treatment, I filmed one session a week. However, in Jeffrey's case, I filmed every fortnight and less later on. Watching video recordings is useful but intensive.

## 2 ITAB therapy

### 2.1 Phase 1 Attachment Therapy

*Phase 1.1: Bonding - Making contact*

Jeffrey went through this phase quite smoothly as expected. This was in big contrast with my previous course of therapy with another client when it took months before she accepted that I would stay in the same room. In this case, it did not require a lot of effort to make contact with Jeffrey. He made contact immediately and responded positively. Sometimes he was busy with something else in the meantime; moving his hands/fingers, moving his body from front to back or kicking his legs. By mirroring these actions contact was easily re-established.

Jeffrey enjoyed proximity. When my head was resting against his head, he was able to turn to me and make pleasant noises. He showed many expressions of enjoyment and could really giggle. In the beginning Jeffrey could quickly get over-excited. I always tried to calm him down in time. In that sense I didn't follow him completely. The sessions were very enjoyable. Nevertheless, in the beginning Jeffrey's mood could change from one moment to the next.
It remained unclear what the reason was behind his mood swings.
My suspicion was that it was partly because of physical reasons (stomach problems, food regurgitating etc) and due to problems in positive stress (excitement) regulation. However, the mood swings did not last long. Jeffrey was generally reassured quickly.

*Phase 1.2 Symbiosis*
The sessions consisted of the same rituals so that Jeffrey could recognise and anticipate what was going to happen. We would first chat for a moment while Jeffrey would be seated in his chair so he could 'land'. Then, I asked him if he would like me to sing the 'spider song' to him. He didn't always respond to this. However, he would seem to recognise the moment when he was tickled in his neck. He would then start laughing already and raise his shoulders slightly. Jeffrey seemed to prefer the head-to-head game. When he bent his head forward, I would immediately react. Jeffrey enjoyed this and would make sounds of enjoyment that I would then imitate. Here too I tried to provoke him by always waiting for his initiative; I would react to that immediately and I would then challenge Jeffrey not to react immediately. Sometimes he would kick his legs out of enthusiasm after which I would stomp on the ground. Here too I would mirror Jeffrey immediately and then wait for him to begin again.

I would also challenge Jeffrey by indicating that he wanted to move to the beanbag. Here I would put the beanbag close by and when he looked at it (at first by chance), I would immediately ask: 'Jeffrey, do you want to sit on the beanbag?' If he didn't respond, I would try again later. If he laughed or showed enthusiasm, we'd move to the beanbag and I would compliment him by saying: 'You have told me so well'. On the beanbag he could lie peacefully with a big smile. But then he would move into action by sitting up. He always found it funny that I imitated him in this. He could also lie quietly next to me enjoying himself. He was usually relaxed and sought physical contact. We would play all kinds of arm games. Here too I tried to provoke Jeffrey to take the initiative. I would also do that sometimes during a game where I would stop and wait for him to take the initiative. Usually he made different sounds that I would imitate. If we had been lying on the beanbag for a while, I would try to challenge Jeffrey by indicating that he wanted to sit on the couch (in the same way as with the beanbag).

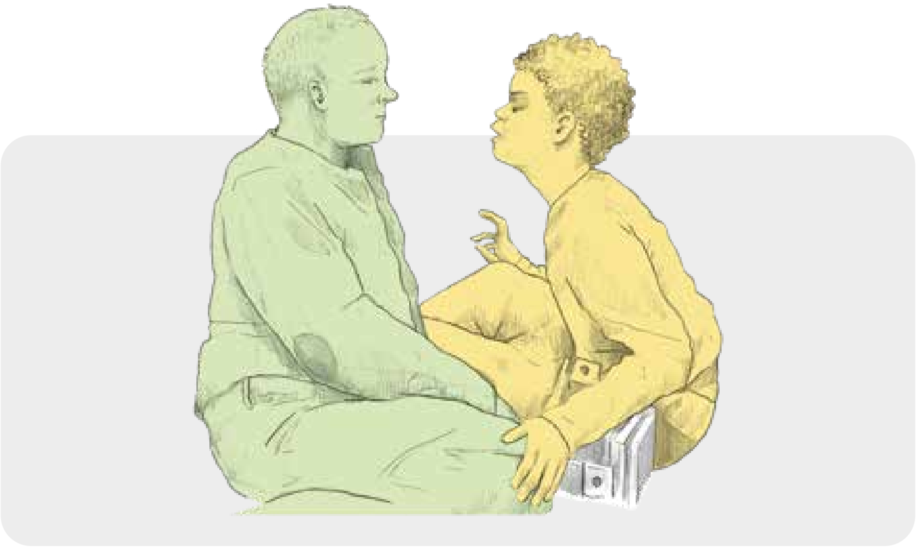
On the couch we also had rituals. One fixed ritual was the song 'Sailing, sailing…', with accompanying movements. The mirror was also a fixed part; it was Jeffrey's favourite. He often indicated that he wanted the mirror by leaning back and looking at it. Sometimes I would try to pretend that I didn't understand him and I would pick up something else. The tricky thing was that Jeffrey was satisfied quite easily. So when he asked for the mirror and I grabbed a cuddly toy instead, he was fine with that too. Jeffrey could have a lot of fun with the mirror. We would play all kinds of games with it. Sometimes I would turn the mirror backwards to provoke a response from him. He would always waive his arm actively in order to pull the mirror towards him. He would follow the mirror from a distance. We continued singing the sailing song and doing the movements in a peaceful way. Usually when Jeffrey started to move, I would respond by saying 'Oh, do you want to sail?' Jeffrey enjoyed being bounced up and down a bit at the part of the song 'Hooray!' I would deliberately stop after the first 'Hooray' and wait for a reaction from him. He would then visibly wait and every now and then, after a while, he would make a movement. I started to wonder more and more however if Jeffrey was still comfortably sitting on my lap. He loved it and could lie happily against me but after a while it seemed as if he wasn't sitting comfortably anymore. Occasionally he seemed to indicate pain by a grimace or a complaining sound or tension in his body. Taking a different posture often helped.

I also tried to stimulate Jeffrey when going back into his chair; I would have him look at the chair, and would ask: 'Do you want to get back in your chair?' If I thought he confirmed that he wanted to go back to his chair I would help him immediately. Jeffrey always felt comfortable when sitting in his chair again. Here we did a game where we would hide under a towel; first Jeffrey, then me. Hereby I challenged Jeffrey to pull the towel away. He had a lot of fun because of this. Usually, he did his best to pull the towel away, sometimes he would remain seated under the towel laughing. We always ended the session with the same song.

*Phase 1.3 Stimulation to individuation*
Jeffrey and I started working with toys and other solid materials such as a red spiked ball, a coloured ball, a mirror, a song book, a reading book, a bear and a bead mill. I tried to provoke Jeffrey to take initiative by having fixed rituals and places for the materials.
We always started the sessions with a quiet landing and a chat. After the opening song 'Itsy bitsy spider', I would ask: 'Jeffrey what are we going to do?' - and would wait for him to look at the basket of toys. He would usually do this. The basket of toys was always in the same place, close by him. If he wasn't looking at the basket, I would ask after a while: 'Shall we get a toy?' or 'Shall we get a ball?' and then wait for his reaction. By explicitly grasping the toy from the fixed spot and letting Jeffrey follow, later he would start asking for it himself. The same happened with the mirror which was permanently located behind the couch. Jeffrey started observing with more focus and learned that he could indicate something with a more focused look. Besides practising to take the initiative 'Show me what you want', we also practised making choices; red ball or coloured ball, ball or songbook. During this game we started working with 'object permanence'; ball, mirror, book out of sight. Jeffrey managed to get the ball out of sight by himself with a mischievous look. It was a lot of fun also to throw a newly built tower of DUPLO off the table. Jeffrey started to realise more and more that I kept the mirror beside the couch. And when he saw the reverse of the mirror was facing him, he tried to turn it around correctly. Jeffrey could have a lot of fun throwing material away. Yet it was also sometimes clear that it could be too much fun. It remained important to regulate his excitement and make sure there was a good balance of excitement without becoming over-excited.

I was able to provoke Jeffrey using a certain toy, because he developed a preference for it. For example, when he indicated that he wanted the mirror and I picked up the bear, I would see the reaction on his face: 'Hey, that's not correct'. Where Jeffrey first seemed to like everything, he now started to show his preferences more and more. Gradually I could leave the room once in a while. This was not a problem. He continued to play with the toy but I also sensed he was waiting for me to return after which he would always react with a smile.

I was not supposed to take Jeffrey on my lap by default any longer. But in his chair Jeffrey could sometimes move a lot. This seemed to increase in the course of the year. Often I managed to break through this by taking him on my lap for a while. In this period Jeffrey started to communicate more.
There was continuous interaction with different intonations of sound. In the meantime, caregivers carried out the ABC analysis concerning remaining challenging behaviour.



*2.2 Phase 2 Learning new positive behaviour*
The ABC analysis showed that occasionally Jeffrey was still biting his hand. In particular the waiting moments seemed to be of concern. He rarely bit his hand during our sessions. If it did occur he seemed to show behaviour indicating that he might feel physically uncomfortable or over-stimulated.

In spite of his enthusiasm Jeffrey often indicated clearly when we should stop for a moment. He would need a few minutes of rest (sometimes even shorter) and then he could continue. It was important to look carefully at those signals and respond to them adequately. Because the hand-biting during the sessions was caused by factors that were not always under my control, it was difficult to change this behaviour. Stimulating his development by focusing on communication was necessary. During the sessions Jeffrey showed a lot of situations in which he could improve his communication. The speech therapist confirmed this and suggested we try working with photos.

A number of photos on A4 format were made of Jeffrey's favourite objects that were used during the sessions. Every time two photos were offered simultaneously, one on the left and one on the right. Jeffrey responded enthusiastically to this and quickly made a choice. Sometimes he had to be reminded to look at both the photos first. When the object that was visible on the photo was held next to the photo, he smiled and looked from the photo to object, and back again. As far as restlessness was concerned, I tried to get him to put his dummy in his mouth by himself. If he was restless, I would say 'Jeffrey that's not necessary' and touched him with some pressure on his shoulder. 'You can pick up your dummy'. By doing so, Jeffrey learned that he could pick up his dummy when he was very restless.

### *2.3 Phase 3 Generalisation/individuation*

Instead of working in his bedroom or in the separate room at the daytime centre, we worked in the living room and in the communal room several times. It was striking to see that Jeffrey was now able to focus even when it was a bit busier in the living room. There was one moment when things didn't go so well, due to unrest in the facilitated care-home following the passing of one of the other residents.

The games with the photos were a success and he often made a well-considered choice. Sometimes I had to tell him to look at both photos first but after choosing, he would reach to the other side (following the chosen photo) if the photos were swapped.

It was remarkable that at some point Jeffrey would stop choosing. He would get fed up with the balls shown on the photos and wouldn't choose between them any longer. When I put these photos away and grabbed a photo with the picture of a reading book, he would react enthusiastically and reach for the photo. Both the caregivers of the facilitated care-home and the day care team have seen video footage of these sessions. There was also a transfer to the teams of Jeffrey's ongoing developments and status including an explanation of the 'Circle of Security' (Powell et al., 2016). Advice was given on what was important in the daily caregiving of Jeffrey and what else was needed. Caregivers were introduced to the Hi Sense APP (www.embinbeeld.nl; see also Van Wingerden et al., 2018; 2019) so that they could increase their sensitive responsiveness. Together with the parents I watched the video of the entire course of the therapy. In the meantime I kept everyone informed both verbally and by written reports.

I believe in this final phase more time is needed for the therapy to be well embedded, so that the continuation of the sensitive and responsive caregiving is ensured as much as possible. In this case I happened to become the developmental psychologist involved with Jeffrey so that I could continue to monitor and adjust the progress. This is not always so in other cases, and I think that more time is needed to monitor a good continuation.

## 3 Completion

Jeffrey positively developed and changed as a person throughout the therapy. All those involved confirmed this: caregivers, parents and paramedics. He became more relaxed and seemed more balanced. He got very upset much less frequently and he became more aware of his immediate surroundings, his world expanded. Especially in the area of communication he showed a lot of development: he started to communicate more and supporting communication has become possible more often. Right now he is able to make different choices within his programme and daily activities. He has also experienced that he can use his body to communicate with others. During the course of the therapy he started using a chair with wheels in which he can move about by walking with his legs. He also started to reach out with his arms and tries to move to things that are a bit further away from him. Jeffrey has gained an influence on his own life! At the same time he clearly shows it when too many things are happening simultaneously, and indicates that he doesn't accept that.

People wondered at the beginning of his therapy whether a reason for his frequent vomiting was related to receiving attention. However, by being very close to Jeffrey, I saw physical signals indicating physical discomfort and there was nothing he could do about it. Of course tension can trigger vomiting. This physical part also received a lot of attention in the course of therapy; various examinations and interventions took place to the physical aspects of his condition. His overall low weight was still a point of concern but gradually he started to gain weight again. The incidences of vomiting decreased. And all of those involved now look at this in a different way. Concerns about his physical well-being however sometimes influence the positive developments. This is understandable but it is important to also keep paying attention to his emotional needs. Especially when Jeffrey does not feel well physically, it is important to have some distraction and experience having fun as well. This remains a point of attention.

My advice to other therapists is to keep a broad perspective and to take other aspects into account as well. Because as a therapist you see a lot of the client and are close to him, you can often pick up on signals. It is really helpful to make video recordings and advisable to edit videos of the whole therapy down to about ten minutes so that the process becomes clearly visible. I myself found this to be a wonderful course of therapy again, that I enjoyed, and I also learned from the treatment process. The results confirmed to me again that this therapy is very beneficial for persons with an intellectual disability and challenging behaviour. I would wish more clients to receive the attachment therapy. It is very satisfying to contribute to the well-being of clients.

## 4 Reporting to the client’s relatives

Kathalijne, Jeffrey’s mother, said: ‘I found the ITAB therapy to be very positive for Jeffrey. Beforehand I can remember thinking it would be very hard work when Renate told me that she would be going to visit Jeffrey two or three times a week for a year. How would Jeffrey react to her? Would he feel safe with her? What could happen then? Would he become less frightened? And what effect would that have on his vomiting? Would he be able to indicate more clearly what he does and doesn’t want? How would he develop? I had all kinds of questions and was curious, but unfortunately I could not observe the therapy myself. That’s why it was so nice to hear in the meantime how things were going with Jeffrey and which steps they took together. It could be a glance or a look of recognition, a smile, a sound and sometimes a clear reaction. The video images at the end of the therapy were beautiful. I could clearly see how he had developed over the months: from an increased sense of security, he was able to indicate better what he liked and did not like, what he wanted and did not want etc. Consciously choosing between two toys, responding to a question or showing that he was happy or over-excited. At last he was able to express his inner emotions and desires. What a milestone! Of course it required a lot of attention and an eye for the subtle signals, but he clearly enjoyed it. And so he does to this day. When I look back on the treatment, ITAB therapy really meant a lot for the development he went through. Today - in spite of his fragile health - he really is doing well and continues to develop every day. Without being able to speak he has learnt to communicate. I couldn't think of a greater gift for Jeffrey!'

## 5 Who is the therapist?

**Renate Hilgers**

As a general developmental psychologist specialist I work at Amerpoort. I have more than twenty years experience in the field of persons with an intellectual disability. My primary focus is clients with severe intellectual and multiple disabilities. In addition to working as an ITAB therapist, I am active in the core team within this facility focussing on these clients, trainer of the LACCS programme and connected to the team that I focused on feeding for these clients.

I learned about ITAB in 2005 when a client living at the care facility 'Amerpoort' participated in ITAB scientific effect study. One of the clients of the facilitated care-home where I was working at that time participated in this study. I became curious about ITAB as a therapy and set the intention to becoming an ITAB therapist after her training to become a developmental psychologist. In 2012 I completed my training as developmental psychologist and followed the Attachment Therapy course in 2015 and followed the ITAB supervision.

An important focus for me in my work is having a good connection. Full attention for the client is extremely important. In addition to coaching caregivers in this, I can also contribute by conducting the ITAB therapy myself. ITAB is a very intensive treatment but it also gives me a lot of energy. I can see the end results. At the same time this therapy suits me personally well and in this way I can continue to use my practical knowledge and expertise in the treatment of clients.

# 3 Case Myrthe

**A woman who is blind and has motor impairment and severe intellectual disability**

*Truus van Ramshorst*

## 1 duction to the case

### 1.1 Intake and assessment

Myrthe and I had known each other for a number of years when I finished my first ITAB course of therapy with Jara. Myrthe’s behaviour reminded me of Jara’s and I often said: ‘Suppose Myrthe hadn’t been in a wheelchair, she would have acted exactly like Jara’. I had my doubts whether Mythe would also benefit from the ITAB treatment. I did not know if Myrthe met the criteria for the treatment, precisely because of the physical disabilities and her almost complete blindness. She lives in a care facility for people with severe intellectual and multiple disabilities. An assessment, using the List of Behavioural Signs of Disturbed Attachment in Young Children (Boris & Zeanah, 2005; Zeanah, Mammen & Lieberman, 1993; Dekker-Van der Sande en Janssen, 2010) confirmed the already suspected disturbed attachment. In addition, case analysis was carried out and anamnesis conversations were conducted with her parents following interview questions of Bakker-Van Zeil (1986).

One of the starting criteria for ITAB is a developmental age of higher than nine months. Because there was no clarity about Myrthe’s cognitive capabilities, we focused the assessment also on determining object permanence. When observing Myrthe in daily situations, it became clear that she was able to find an object again after it had disappeared from sight. A request for additional care was submitted to finance the ITAB therapy and the associated ‘extra support’. The request was granted when Myrthe was 25 years of age.

### 1.2 Preparation ITAB

In the meantime, a doctor specialising in intellectual disabilities and I (a developmental psychologist and therapist of Myrthe) prepared to present psycho-education on attachment for the caregivers in her home care facility. Myrthe suffered from many health issues, which could not be explained by medical analysis. Some examples included; experiencing pain: but where and why?; and difficulties in taking her medication. A connection with stress and anxiety was suspected as the cause of these problems. The psycho-education was a multi-disciplinary collaboration to talk about the issues we were all struggling with. We all felt very insecure about our caregiving, especially because no medical concerns were found for example in her throat, hips, or her back. She showed self-injurious behaviour while she was eating seated in her chair. The self-injurious behaviour consisted of pulling her hair hard for no obvious reason. The caregivers recognised Myrthe's behaviour in the case presented on the video 'Attachment: A Psychotherapeutic Treatment' (Bartiméus, 2007). It was hopeful and promising that the therapy could benefit Myrthe. In the same week there was a conversation with the parents. Because of Myrthe's long lasting physical discomfort and restless behaviour (crying loudly and wailing), her parents had started losing their hopes of improvements of Myrthe's quality of life. They had expressed these concerns and had lost faith in any improvement. There were meetings also with the social worker. These were difficult conversations as everyone talked from their own role and involvement, both the parents as well as the professionals. It was important to gain the parents' trust in the potential of our chosen therapy. Understandably they had concerns as a result of their previous experiences with Myrthe. However, they also saw some similarities with the client shown in the video which they found reassuring. Eventually, after having received funding for the treatment, the therapy could start.

Myrthe lives in a relatively new home care facility where she has an own apartment. This was a good location for the start of therapy. I visited the residence a few times beforehand so that Myrthe could get to know me and started being familiar with my voice (which was important as she is blind). The caregivers made sure that Myrthe was on a waterbed when I would come to visit her. I had chosen for this routine consciously to keep the transition from one person to another clear for Myrthe. Next to this, I was not able to operate the hoist. I had put a notebook on the table where I wrote about my observations during the sessions. This way, parents and caregivers could read my experiences and could respond to this if needed. Writing the notes became a nice ritual to end with. Then I would put my shoes and coat on again and when zipping it up I would say: 'Do you hear that

Myrthe? I'm ready, I'm going' and said 'Bye' three times as I noticeably walked away. For the first three months I visited Myrthe three times a week, and, due to practical reasons, twice a week thereafte.

## 2 ITAB therapy

### 2.1 Phase 1: Attachment Therapy

*Phase 1.1 Bonding - Making contact*

Initially Myrthe experienced a lot of stress. This was noticeable in her behaviour: She started to pull her hair very hard and to bite her hand. To prevent this I would reassure her, hum a bit and would talk in a calm way. I held her hand and she would follow my movement. As soon as I let her hand go, she would immediately grab her hair again and start moaning. Only after about fifteen minutes of reassurance and making a movement where I gently supported her hand, would she become more relaxed and bite her hand and pull her hair less. She was also curious and seemed to seek contact with me and approach me. She would move her hand in my direction and would try to find mine.

By sharing my experiences of witnessing Myrthe's self-injurious behaviour, caregivers felt understood and supported in their concerns about her. At the start she showed self-injurious behaviour; this was a new situation for her and therefore it was also a stressful situation.

The first two weeks she was still very restless after the session and this would continue all morning during her time at the activity centre. Because this continued, we agreed to move the sessions to the end of the afternoon. This way her routine in the morning was as usual again, uninterrupted by the sessions. This programme turned out to be much better for Myrthe. Due to her visual impairment (blind) our contact was mostly through body language. She immediately loved the hand clapping game with different intensities and rhythms. She was well able to indicate when she wanted more of this by repeating a gesture or clapping faster herself. She could get very enthusiastic when singing our self-made song in which we gradually went from 'slow' to 'faster' to 'even faster' to 'super-fast'. Soon she was able to indicate that she wanted this song and when she wanted it to go faster (similar to the game: 'this is the way the ladies ride... and this is the way the gentlemen ride').

Another form of contact with her hand was still quite difficult because she would usually lie on her back and could not easily turn due to her severe physical disability. When she allowed me to come closer with my head, she would often start touching my mouth, nose and face. My mouth seemed to be her favourite: it contained movement, tension and literally music. She could also physically push me away from her again. I interpreted this as ‘time to take a break’. Sometimes she was restless and had a toy with which she tapped her teeth quite forcefully. Normally she gave the toy back easily, but when she was tense she would hold it with a tight grip. It could get rough: just the sound of the hard-plastic toy tapping her teeth gave me goose bumps.

Myrthe noticed the structure in every session quite quickly. There were built-in rituals leading to increased predictability, for example by introducing a fixed starting ritual followed with a closing song (where we sang ‘stop’ five times and then ‘done’). We built in our own common rhythms with songs that matched the undulating movements of the waterbed. This way we could move back and forth together nicely.

I always had to remain alert to her limitations: the severe physical impairment of her left hand and her blindness. For example, she was very frightened by an unexpected noise. We also had beautiful moments together on the waterbed; after waves ‘back and forth’ I would do nothing for a little while. I would then wait a few seconds until I called: ‘There we go again, faster, faster and faster’. Later I noticed that she would take the initiative in this. By pushing her arm against me with a very subtle movement (from which I interpreted that she wanted us to continue moving again) I started the movement again. She would repeat her subtle arm movement towards me when I stopped. With her ‘pushing arm movement’ she started to indicate more clearly that she wanted to swing ‘back and forth’ on the waterbed. She was excited when she knew I would make her move faster and faster: she would have fun beforehand and laughed once we moved up and down a lot. Because this was recorded on video, we were able to show others involved in Myrthe’s treatment how much fun these interactions were. In daily life she now also started to reach her hand out more and more for contact games. First, everyone had to get used to this ‘new Myrthe’. However, there were still moments where she could also try to bite your hand without any warning. Nevertheless, the intensity of the behaviour which caused self-harm became less and less and others slowly started to find it more and more enjoyable to make contact with her.

Gradually a sense of togetherness was formed. Myrthe could take initiatives and could sometimes surprisingly well indicate with her hands whether she wanted one or the other movement. And so I had to invent and adapt certain songs in order to be able to perform them in a rhythm that ‘suited us’. She liked many things only for a short time. She challenged me often to come up with something new and if I succeeded, I was rewarded with her laughter. She wanted to repeat this ten to fifteen times. I remember a birthday song, with the name of a person familiar to her (Mum, Dad, sister, caregiver) ending with ‘Hooray’ where we would all swing our arms in the air. The intensity of her swinging with her arms was a good indication of the level of stress in her body. Often her arms didn’t come up very far, but sometimes they would rise up quite easily. I could gradually start to challenge her more and more using movements that would go with a certain song to a part where we would ‘wait a second’ after which we started to understand that she had to do something in order for me to continue singing. This happened with the Dutch song ‘Piet de Smeerpoets’ (‘Filthy Pete, go and wash’) in which you would first touch your hands and then your feet, knees, head, hair, and finally your cheeks.

With this form of contact and songs I was able to challenge her more and more to ‘wait a while’ and then she gradually understood that she had to do something to start me going again. With these songs the focus during the treatment was to have in-tune and out-of-tune contact. Each time I had to wait a while before she would indicate whether she wanted to continue. I had to continue to adapt accurately: Myrthe was very clear about what she didn’t want (pushing away, turning away etc.) but sometimes it was quite difficult to find out what in fact she did want. The very close physical contact where we were lying together face to face was very special. She was almost always moving her head and you could feel how exciting she found these contacts.

Meanwhile Myrthe started to get the idea that you can make different movements with your hands and with your body. Examples included: clap your hands, move from left to right and move your head down towards your feet. I would make my gestures very big and always say that she could ‘indicate it so well’. I complimented her by saying: ‘You are so clever’. Because she could hardly move her body it was not that easy for her to make these movements. What did go well was to include her impaired hand when rolling over and during play. She had a sense of humour and I was able to respond well to this. We were well on our way to the phase of symbiosis. In her exploration of my face she started to feel more and more with her hand and sometimes with her mouth. She noticed that she was able to direct me; when she pushed her hand on my mouth, it started to move and sing. She found this a great discovery. I used this discovery with great pleasure and in multiple variations: my mouth could also blow or make sounds for example.

After more than five months, a very difficult period started for her, where she experienced a lot of stress and tension in her body. This period lasted from July to October. We were forced to look for new forms of contact but she could only keep it up for a very short time. There was a lot of tension and restlessness in her body. The sessions cost her a lot of energy and she started to look increasingly tired. During night-time, she couldn’t catch her sleep and then would fall asleep lying next to me. Everyone was worried and sad about this and as a result for the first time her parents and caregivers spent more time with Myrthe. Despite her crying fits and the deeply unhappy impression made, her parents and caregivers indicated that these were interspersed with beautiful (contact) moments. They reported that these moments were new to them and that in earlier difficult periods, before starting the therapy, there were hardly any such moments. We could tell by looking at her when she didn't want or couldn't make contact for a while. She was able to indicate this very well. It was difficult to see her in this state and we felt quite helpless, but something had also changed in the contacts with her. This gave us all the courage to continue. Myrthe's experience of us also being there for her when she was having a hard time seemed to have a positive effect. For me as the therapist, but certainly as a developmental psychologist of Myrthe's team at her home, it made sense to include these experiences of hard times in the conversations I had with the caregivers.

### *Phase 1.2 Symbiosis*

At of the end of October a few peaceful months followed where Myrthe was generally relaxed. She was able to indicate better and better what she wanted, like the handclapping game and 'waving' the waterbed together. How slow or how fast she wanted this was not always easy to see, however there certainly were more and more moments of 'real' contact. She went along with the movements and would also take the initiative herself by starting a movement or by moving her head closer to me.

In daily life people saw that she could enjoy action-reaction games and that she had more peace of mind. In December we experienced a highlight in Myrthe's life. During the big Christmas celebrations she sat quietly at the table for the first time with her family and her daily caregiver. This had never happened before and she kept it up for quite some time. Everyone enjoyed this. It was lovely to see her parents sitting on either side of Myrthe. Also her sister and half-brother were there. She was happy and seemed to enjoy the music, food and the atmosphere. I thought this was a golden moment. After ten months of therapy we could move on to the next phase: 'stimulation to individuation'.

### *Phase 1.3 Stimulation to individuation*

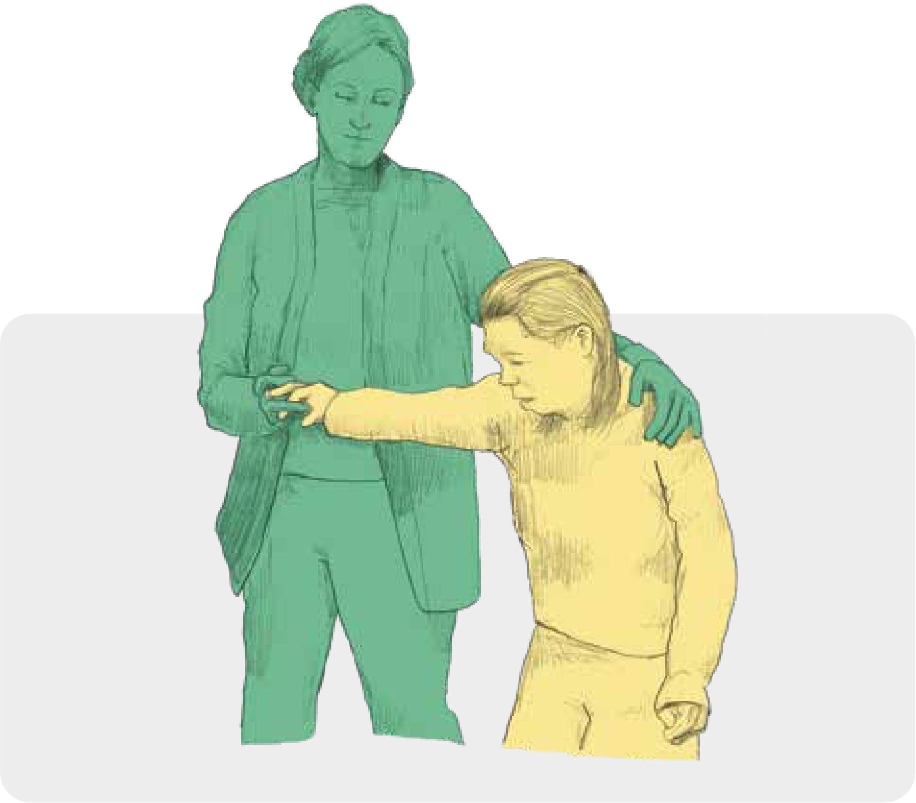
In this phase Myrthe was challenged more to do one thing after the other and toys were introduced. But she actually preferred to play with me or with my hand. After continuously offering the toys, she would however laugh at unfamiliar things I presented her. Examples of these toys were bells and a clown which rocks softly back and forth while making a sound. She found this interesting for a short time and sometimes she managed to change from one game to the next. This remained a challenge because she couldn't see the toy and therefore couldn't easily pick it up and could not feel it with her mouth.

Myrthe mainly made a sound when another person also made a sound. She went along with the greater variety of hand and arm movements and the waves on the waterbed. She really loved looking for toys that I was hiding from her, giving her little clues where to find them, like rustling paper. We had done this before with my hand on her leg and belly (through feeling) and now she went looking for the sound. At first it took her a very long time to find the paper but with my encouragement and by repeating the rustling sound she would be able to find it more quickly. She needed the challenge of such activating games on the one hand and also humour on the other hand. If you accidentally waited too long or were too far away from her, she wouldn't participate anymore.

Myrthe's waterbed was small. The 'take turns' game was only possible when you were lying next to her. The purchase of a larger waterbed turned out to be a golden touch. At first it did not go very smoothly and she had to get used to it, because the waves went slower and she had to be more patient for them to return. She learned this very quickly. In the small waterbed she could roll over easily by always holding on close to the edge. In the large waterbed this took her a lot more effort. However, it also seemed as if she could really enjoy moving around: rolling over herself using her arm, waving her arms around a few times. She was given a lot of freedom of movement in the new waterbed and now she could amuse herself for a while moving and rolling over. Also at her activity centre a new large waterbed was installed, which was nice. Now it was also easier for caregivers to lie down next to her and play with her by mirroring her.

*Continuation: search for suitable toys*
Within the therapy, Myrthe was able to play with the toys even though she still found it difficult. We found toys that had buttons to turn on sounds and music. She loved this. For her father the video recordings of Myrthe being enthusiastic were a good sign. Besides the calmer behaviour, he saw that she could laugh out loud again because of the crazy music that the toys made. They had to be offered in doses

because she sometimes could get over-excited. It was difficult that most of the toys were made of hard plastic and this was not safe for her. She could hit her teeth or head with them out of the blue. Soft toys, however, didn't interest her. In daily life with trusted people next to her, she mostly focused on physical contact. She pulled people towards her and would push them away again. Myrthe could amuse herself well with music. The caregivers had made three baskets filled with toys which made sounds, to suit her mood at that time. She also liked an audiobook. What she exactly understood from this, we to this day do not know, but these seemed to have been enjoyable activities for her.



## 2.2 Phase 2 Learning new positive behaviours (after eighteen months of therapy)

During a multidisciplinary consultation we discussed the observations of the challenging behaviour that persisted. The challenging explosive behaviour would occur significantly less often. These episodes lasted shorter and were easier to break through. This was the case both at her home care facility and the day activity centre. Dinnertime at the home care facility proved to be a particularly vulnerable moment for her. These moments had already been brought to the attention of the team by discussing them with the help of video recordings. Also the transition moments were vulnerable, for example when moving from the chair to the waterbed. At the activity centre however the moments that led to increased tension happened during ‘waiting moments’ before and after mealtime. Attempts were made to reduce the stress with the help of songs and by creating more predictability. During the therapy I was able to practice ‘having to wait’ or quickly having to switch to something else. However, this was of limited use in the therapy. The focus of this was in daily life. Over time Myrthe’s behaviour calmed down. She was able to wait for longer periods of time, for example when waiting for her father who came to get her to go swimming together. Previously this had always involved an excited and tense departure. Taking everything into account it seemed that Myrthe was still developing in her communication skills. A speech therapist was engaged to support her in this.

## 2.3 Phase 3 Generalisation/individuation after about twenty months of therapy

In June we decided to slowly complete the therapy. In that summer however a more difficult period followed. During this period Myrthe’s sleeping worsened because of the heat, the holidays and also the fact that her therapist was gone for three weeks. However, this was not as bad as the relapse that she had experienced the previous year. This time, the crying fits were less severe. It took a few months until she relaxed again and her sleeping improved. The team indicated that this time it was possible to stay in contact with her and that this was different than before. The phasing out of the therapy was postponed until the end of September. I started shortening the sessions and then slowly reduced their frequency.

# 3 Completion

The therapy seemed to be successful. The search for suitable toys or other activities for Myrthe seemed to remain a challenge however. The search continued in a so-called ‘play therapy contact’ and caregivers were supported in this. Three months after the start of the ITAB therapy, an improvement in Myrthe’s behaviour and contact was evident. Since I was also the developmental psychologist of her home care facility, I was able to follow her process in this role too. That was very stimulating and effective. The team of caregivers of the care facility led and it was not always easy to sufficiently involve the caregivers at the activity centre or parents in this process. This required a lot of consultation and coordination. If those involved went too quickly or too slowly this could cause stress. Because of my dual role as a therapist and developmental psychologist at the home care facility, it was very effective for me to be able to take the necessary steps myself when I saw reason to do so. The lines of communications were short and that was pleasant and effective. On the other hand, it could also be complicated to have this dual role, for example when after a period of clear progress there would be a period were things went less well.

In my experience, it is necessary to do a handover and generalisation to the client’s day care location. This benefits the client as well as the caregivers of the day care centre. It is pleasant if this phase of generalisation leads to more peace and confidence in the contact with the client. For me as a therapist, it was particularly special to notice that Myrthe seemed to get to grips with a number of things so quickly. This proved that she can still learn and take developmental steps. When taking her limitations into account, it was not always easy to find suitable games/toys for her to play with. She has changed a lot in the way she is able to make contact and how she allows contact in moments of stress and tension which has benefitted everyone involved. It was a bit of a challenge finding a suitable space and facilities. The large waterbed provided the opportunity for playful contact with caregivers. In addition it gave her more room to move, which is very important for someone with such a physical disability. Now that the therapy has been completed, Myrthe appears capable of building up relationships of trust with several people, in which she can experience a sense of safety and security.

## 4 Reporting to the client’s relatives

Caregivers and parents experienced the therapy to be a very valuable process. They think Myrthe has really made progress. During moments when the teams of caregivers and I radiated enthusiasm, we noticed that the parents were more cautious than we are in raising their hopes and expectations regarding the life of their daughter. However, they do agree that Myrthe significantly more often enjoys life. The second Christmas celebrations were also successful. It is very nice for Myrthe’s mother that she can now lie down on the waterbed next to her daughter and have close contact together. They once actually even fell asleep together. The mother was very surprised about this and found it a beautiful moment. Her father now experiences close contact in the weekly swimming sessions with his daughter.

There are certainly still difficult times. Nevertheless, the therapy process with parents, the doctor specialised in intellectual disability, the personal assistant and the social worker has allowed us all to close the topic ‘unbearable suffering of Myrthe’. This was very encouraging for all concerned. We were able to discuss concerns and also the pleasant things openly and honestly with each other.

## 5 Who is the therapist?

**Truus van Ramshorst**

I am a developmental psychologist and mental health psychologist and play therapist and I have been working at Esdégé-Reigersdaal, the Netherlands, for more than twenty years. This is a centre for providing support to people with (intellectual) disability, in the province of North Holland.
I specialise in supporting people with severe intellectual disabilities and I am also part of the national Platform for Severe and Multiple Disabilities (‘Landelijk platform EMG’). Here I work on improving the quality of life for people with severe intellectual disability. This is a great passion of mine and challenge. From that passion, I have developed, together with Paula Sterkenburg, and shaped the course ‘Building a Relationship of Trust’ within our organisation. This course fits perfectly with our vision that ‘real contact’ is one of the most

important pillars in our lives and therefore also for the people we work with.

Another part of my work consists of giving therapy and advice to clients with mild and moderate intellectual disabilities and their parents and caregivers. Both in my own practice for play therapy ‘Spelkamer Luttik’ and in my work at Esdégé-Reigersdaal I have specialised in the treatment of attachment problems. In my work I apply the ITAB course and the differentiation and phase therapy of J.C.A. Thoomes-Vreugdenhil, which enables me to be a therapist for children both with and without disabilities. These therapies often last longer and this personally suits me well. My work as a mental health psychologist at Esdégé-Reigersdaal and my work as play therapist in my own practice ‘Spelkamer Luttik’ complement each other very well.

# 4 Case Peter

**An adult man with severe intellectual disability, epilepsy and problems with stimulus processing**

*Marianne van Groenigen-Hulst (ITAB therapist) and Mirjam Wouda*

## 1 ntroduction to the case

### 1.1 Intake and assessment

Peter is a well humoured adult man with a severe intellectual disability, epilepsy and problems in processing stimuli. He was born with microcephaly as a result of which he misses the left side of his brain completely and the right side only partially. As a baby he was abandoned by his parents and was later adopted. His adoptive parents are very involved. Peter's behaviour is often problematic around meal and drinking moments, this has been the case since early childhood. When Peter feels uncomfortable, he self-injures (biting his hand, banging his head). In the past six years it has become noticeable that he has been coughing a lot and also gagging, drooling, spitting (saliva) and having to swallow a lot. Medical and social behaviour assessments have not provided any leads that have improved these issues. Peter suffers from this condition and it regularly leads to him vomiting. It prevents his environment from cuddling him and making any physical contact. He seeks the proximity of his caregivers, he follows them around and likes sitting on their laps. He sometimes grabs the hand of a caregiver in order to guide him somewhere so that he can clarify something. Physical contact can be rough. He can also push caregivers away; he does not always like to be comforted when he is sad. He mainly communicates through his behaviour; he understands the words 'yes' and 'no' and is able to use them.

In 2015 Peter's assessments were conducted focusing on disturbed attachment. These assessments consisted of using the List Signals of Disturbed Attachment Behaviour of Boris and Zeanah (2005) and Zeanah, Mammen and Lieberman (1993) in interviews and observation. Interviews were held with the caregiver of the day care centre and a caregiver of the home care facility. In addition, a review of his file was carried out to further examine his history and behaviour.

Finally, the assessment was completed scoring the list while analysing the video of the Clinical Observation of Attachment (COA) procedure. The total average score based on the assessment (following the method described by Dekker-Van der Sande and Janssen, 2010) was 26.33 and indicated disturbed attachment. On the basis of these results, Peter's severe intellectual disability and his history of adoption and challenging behaviour, it was advised to start with the ITAB therapy. After consulting with Peter's legal representative, he was registered for ITAB therapy at the treatment and counselling point of the care facility where he lives and participates in day care activities.

## 1.2 Preparation ITAB

After having read Peter's case file and the development of his attachment thoroughly, I explained the outlines of the treatment, it's purpose and how I was planning to start with the ITAB therapy, to his legal representatives and personal caregivers.

Given the intensity and length of the treatment, I found it important to create a broad base of support for it. I also requested written permission to film each session. I also worked with a digital baby monitor so that the caregivers could see and hear what I was doing as there was no window or peephole in the bedroom door. The disadvantage for me as the therapist was that I did not know who was watching us and whether the caregivers had been following the session. Even though it was good that the caregivers could follow what we did (accessible/open) at the same time I was very aware of the fact that everyone could see and hear everything. This was sometimes complicated as the therapy could be underestimated and misjudged. Caregivers were critical and wondered what I was actually doing: ‘Well, following Peter so calmly and going along with everything is something we can do too.’ Despite my personal objections, however, to create a sense of security for the client as well as for me, the therapist, it was of greater importance that the sessions could be followed by others. It also gave caregivers the opportunity to share ideas on a sensitive and responsive approach and on building a relationship of trust.

Together with Peter's personal caregivers, we agreed on fixed days and times for our sessions that suited his day programme. Peter is mobile and walks around a lot. The legal representatives gave permission for us to lock the door during the first session so that he couldn't walk off. However, this turned out not to be necessary. He was easily distracted and we therefore chose his bedroom where he had a couch as a location for the sessions. We agreed to meet two mornings per week, after which I would take him to the day care centre myself in order to limit the transitions. The third time this order was reversed and I picked him up from the day care centre and we went back to his home together. He always had something to drink after his daytime activities. His routine of practical care reduced our timespan to focus on building a relationship of trust. However, caregivers would actually prefer that I would be the one giving him his drink. After a while, we agreed that the caregivers could resume giving him his drink to keep clarity on who did what. This required some discussion with the caregivers, however we ended up agreeing on this in a pleasant way.

A consultation with parents, mentor and personal caregivers took place every six weeks. Once every quarter we also held a meeting with the caregiver at his home care facility and his day caregivers in order to include them in the treatment process. We did this to strengthen support and to eventually work towards the transfer to his caregivers (generalisation phase). It requires some creativity and time to explain and practice this in a practical way.

## 2 ITAB therapy

### 2.1 Phase 1: Attachment Therapy

*Phase 1.1 Bonding - Making contact*

Initially I started to mirror Peter's behaviour to make contact. In doing so, I followed his pace. In his bedroom we would walk back and forth many times from the door to his window. I would mirror when he stamped his foot, tapped the windowsill, his door or his bed. The first few times he would walk to his bedroom door and open it, sometimes he would also leave the room. I would then follow him, but he would not be interested any longer in continuing the session and returning to his room. After a few times I was able to distract him from leaving the room by walking back and forth and choosing the side of the door handle myself. This would distract him from opening the door by himself and walking out. He enjoyed slamming the door forcefully and having me mirroring the sound of it by pounding the floor loudly. In the first sessions I did not seem to be the focus of his attention; instead he continued moving around in his room. However, after a few sessions he already started noticing me mirroring him, which was striking. It seemed as if he would deliberately do certain things, for example tapping his own bottom, to see if I would mirror this. This began after a month of treatment.

This gradually shifted his focus on me mirroring him and on me. A ritual began where we sang a song together at the beginning and end of each session. Each session started by singing a Dutch song where we would stack our fists on top of each other ('Deze vuist op deze vuist') and ended with a song 'Bye Peter, this is the end…'. The physical distance between us during the sessions was mainly determined by what he felt comfortable with. In the beginning he strongly resisted physical contact and of course I respected that. As the sessions progressed, he gradually started seeking more physical proximity. He would accept me moving closer to him when he would get a coughing fit that could turn into gagging or even vomiting. He sometimes even seemed to seek support by leaning against me placing his hand and face on my shoulder and looking at me. But he would initially forcefully push back if I would then place my arm on his shoulder or back. Physical contact was only possible when he took the initiative himself. When he did initiate this I would allow it and would be very caring, never rejecting him in such a moment.

I put on a jumper with a high turtleneck over my clothes every session as a protection against his saliva, as he would sometimes make contact. This way I would be able to remain clean for the rest of the day. Even though he produced a lot of saliva and would sometimes gag, I always allowed him to make contact. Another month later we were very well able to make physical contact. We would sit next to each other on the couch in his bedroom where I would sing songs. Later he would put his legs on my lap and even later he wanted to sit on my lap. We were able to make eye contact for a few seconds only at first, but soon he was able to do this for longer periods of time and eventually he wouldn't look away anymore. Mirroring remained an important part of our sessions.

*Phase 1.2 Symbiosis*
Singing together while Peter sat on my lap led to closer contact between us. He would sit facing towards me. We were able to move along with each other and make sounds together as I was able to anticipate his behaviour very well. Sometimes we were even able to make synchronised movements and sounds as I had got to know him very well. Sometimes it almost seemed as if he was crying and I could sense a lot of emotions. In this contact we would gently rock back and forth along with the songs. Fixed rituals were introduced; we would repeat certain games and songs like ‘Here comes a little mouse…’ which created greater predictability. We would repeat them endlessly. When hearing the first words or tone, he would immediately know what was about to happen. This phase included more variety at the start of the sessions; sometimes we would sing a song or start off with a game. During this phase of symbiosis there was a one-week interruption due to the holidays which worried me slightly. However, after a week he recognised me immediately at the first ‘Hello’ and we were able to resume the sessions as if nothing happened. This meant that the symbiosis could be broken off and then restored again.

We would rock back and forth with our backs together. I placed a large mirror in the room so I could see his reaction. This turned out to be very nice when Peter sat on my lap and we played contact games as we then could also look at each other in the mirror. It took a while for him to understand the fun of this, but once he did so he enjoyed it a lot. Playing together gradually became more ‘in-tune and out-of-tune’. For example when I would stop in the middle of a song or poem and waited, and he would indicate that he wanted me to continue. At first an indication could be a very small signal such as looking at me or making eye contact. Later I would provoke him by waiting longer for a signal in order for him to indicate even more clearly what he wanted. This was often the continuation of a game or song. This game further developed in the next phase.

### *Phase 1.3 Stimulation to individuation*

The ‘in-tune and out-of-tune game’ further developed in this phase. I would continue to provoke Peter to indicate more clearly what he wanted. If he did so I would reward him by responding to his request such as by singing a certain song, continuing a poem or playing a game. Each time I would end ‘in-tune’ so that he would continue to feel safe to take the initiative. This led to a different form of playing, where we took turns. We would imitate each other’s sounds by both clicking with our tongues for example. He showed more and more variation in sounds he made during the sessions. He clearly enjoyed this form of ‘conversing’ where we took turns making sounds.

Between the moments of playing together this phase allowed space for behaviour that matches with the Symbiosis phase (Phase 1.2) such as sought comfort, proximity and safety. These periods occurred less frequent over time and each time, after a while, I would stimulate to start playing again. This is an important element of the ‘Circle of Security’. If I only offered him comfort, he could ‘get stuck’ in his crying fits and would keep seeking comfort. After he received comfort, it was important for him to continue exploring his environment again and play. I would initiate this distraction by offering him a toy to play with and we would start playing with it together.

It was examined whether Peter had a notion of object- and person permanence. This was simply practised by hiding an object partially and later on hiding it completely in order to see whether he would then start looking for it. However, this did not require a lot of attention, as he immediately knew where to look! This was important, as he had to learn that when something or someone disappeared out of sight for a moment, that person didn't *actually* disappear but could still be present and could re-appear in sight again. At this point toys were introduced into the sessions. At first, we would play with them together and later he would play with the toys by himself. He appeared to prefer oys which reacted when he touched them, such as activity centres. One activity centre (an older version) had buttons which made sounds when pressed, where the other had batteries and would play different melodies. After a lot of demonstration and with encouragement to try them out himself, Peter could eventually spend as much as five to ten minutes playing with them. He would throw toys which were not attached to anything, so at the day care centre as well as at his residence he started wearing an apron on which they were sewn. This way he could easily play with them. During the sessions I tried to calm him down when he would throw toys. I would not get too excited by it or give it much attention. Eventually Peter and I would simply put the toys back in the bag. We started practicing this by me gradually taking more distance from him as he was playing. First he would sit on my lap or on the couch, later I would sit on a stool gradually moving it further back and to the side. In the meantime I continued to encourage him by saying that he was playing so well. I responded when he made eye contact by encouraging him to continue. In the end we practised him continuing to play alone even when I left the room. He was able to do so step-by-step; first for a short moment, then a little longer and finally for a few minutes. Sometimes this would go better than others. Sometimes he would have remained seated on the couch with the toy on his lap after I had left the room, however he had stopped playing and looked at the door, waiting for me to return. Nevertheless, after I had returned to the room, I would always make sure that we would re-establish warm contact and reward him by complimenting him on how well he had remained seated and continued to play. After that, I would take a place in the room where there would be some distance between us again.

## 2.2 Phase 2 Behavioural therapy

Caregivers indicated that Peter's saliva loss was the most difficult part of the caregiving. He sometimes also spat when biting his hand and occasionally this was followed by banging his head against a wall.

After conducting the ABC analysis it became clear that different caregivers reacted differently to this behaviour: sometimes it was ignored while other times it was addressed in a corrective manner, or he would be told the caregiver would come back to sit with him again after a little while. Other times caregivers would take him on their lap or they would move on to the next part of his program. It seemed that the undesired behaviour mostly occurred during a part of transition in the programme or when contact with the caregiver was disrupted for whatever reason. The behavioural therapy phase about learning new desired behaviour after which the undesired behaviour fades out on its own. Essential here is to reward social behaviour constantly by giving positive attention or a compliment.

Thus, we started an exercise where Peter indicated what he wanted by stroking my arm, shoulder or back. I would sing a song and then ask him if he wanted another one. If he nodded ‘yes’, I would reply: ‘Please stroke me’ and demonstrated what I was expecting. When he would do so I would compliment him on this extensively and reward him immediately by singing him a song. We also practised blowing bubbles: ‘Do you want me to blow more bubbles? If you do, you can stroke me on my arm.’ If he would do so, I would also compliment him profusely and follow up on my promise immediately by blowing the bubbles. After about five or six sessions Peter started understanding the concept of reward following this desired behaviour (stroking) and started to stroke actively. At first this happened only when I was facing him, but later also when I would have my back turned towards him such as when I was supposedly looking out the window or when I was ‘writing’ down something in the notebook.
We did this because I knew that later on not every caregiver would be facing him when sitting in the group and it would be good if he then would also be able to indicate something clearly or ask for something.
Later in day-to-day activities the team of caregivers noticed that he seemed to be more focused on them. He also started communicating more, pointing at something he wanted to drink and asking for someone’s attention by indicating something while walking outside (joint attention). An example of this was when he went for a walk with his mother once and pointed in the direction of a cat sitting in a windowsill. To further investigate if he would be able to improve his communication skills, an appointment was made with the developmental psychologist of the home care facility and the speech therapist. In addition, I set up a meeting with Peter’s two personal

caregivers and the developmental psychologist to discuss how the new desired behaviour could become part of the daily caregiving. We now entered into the phase of generalisation.

### 2.3 Phase 3 Generalisation

In our one-on-one sessions Peter demonstrated the new desired behavioural alternative: stroking instead of spitting. Immediately after that he received a social reward of compliments or one-on-one focused attention such as by thinking of what he wanted. Possibly by asking: ‘Do you want a song? Do you want me to press that button again? Do you want me to blow bubbles again?’ I noticed that the system of rewarding encouraged Peter enough to show the desired behaviour over and over again.

Peter’s sense of security grew as our contact developed. He started experimenting more and more in our contact for example by making jokes. In a team meeting the learning of behavioural alternatives was further explained and discussed using video recordings. The caregivers all agreed to start working on this. Some caregivers wanted to start working on this with the help of a therapist, and so this was agreed. Subsequently, both personal caregivers participated in the therapy session once, so that they then were able to support their colleagues in its implementation. The sessions that followed took place in the living room, for example during daytime activities or during the moments where they were having a drink at the residence. This was important because it allowed him to sharing attention and I myself could be a model (an example) to the caregivers.

Peter continued to play with the activity centre and toys that were similar to it. The play therapist was asked for advice on which toys could be best offered because at that moment he seemed to be taking steps in his development in this area too. The (Dutch) Centre for Consultation and Expertise (CCE) committed to finance a proper implementation of Peter’s treatment for the following two years. This money was used for the video training with guidance of the developmental psychologist and the ITAB therapist to implement the style of caregiving and to strengthen the effectiveness of the use of the ‘Circle of Security’.

Recommendations for the client’s treatment plan:

- Work on the ‘Circle of Security’. Be a safe haven where Peter can find comfort, share pleasure and be in control of his emotions and feelings. Be a secure base from which Peter can explore the world around him.
- Stimulate alternative behaviour (such as petting) when Peter shows unwanted behaviour (such as spitting).
- Look at every small signal Peter gives to make contact, to communicate.
- Reward desired behaviour by giving a compliment; focusing on him and giving him real attention for a moment.
- Be sensitive and responsive to Peter.
- Have fun with Peter by playing contact games together.

## 3 Completion

Peter has learned to build a bond with the trusted other. In the course of time he started showing more affection and was able to indicate more clearly if he sought comfort or help. In addition, he enjoys doing things together. There is shared attention (joint attention) for the world around him/his surrounding and he can amuse himself on his own for longer periods of time (exploration). He still spits sometimes, but much less frequently. He asks for attention by stroking instead of spitting. This makes it more pleasant and easier for caregivers to make contact with him and he is also more open to receiving contact when a trusted other initiates this.

In my experience, working with a team and enabling generalisation of the treatment into daily life can come with certain challenges and dilemmas. Although Peter’s team of caregivers was very motivated to improve his situation, they were also sceptical about his capacity for improvement and their own abilities to influence his behaviour and establish change. It took some time for ITAB to have a visible effect. Sometimes improvements were not directly evident. Psychoeducation, offering a clear understanding of the need for the therapy and the changes in the therapy and the relationship with the client are clearly very important.

In this case, the course of treatment progressed quickly. Peter's emotional and cognitive abilities developed significantly. The biggest challenge was to bring about changes in his daily environment and including caregivers. This was sometimes difficult, due to working shift planning problems and having temporary staff. Therefore, the implementation phase required extra attention. A solution to this was using training videos aimed at improving sensitivity and responsiveness. For me personally however, it was sometimes difficult to ensure a situation of continuity, as the team was incomplete from time to time. Of course as a therapist, you have no control over these external circumstances.

## 4 Reporting to the client's relatives

Peter's parents and legal representative clearly noticed that he was more open to his environment. He pointed at things others needed to look at (joint attention). More often he would be able to ask for attention in more desirable ways than spitting. Also, after a caregiver started to practice 'asking by stroking' he started showing this behaviour more with that person. He sometimes also just seemed to do this for a positive contact moment as the social award for stroking was a compliment and a great encouragement for doing so. These contact moments had a positive effect on the relationship with the caregiver in such a way that it had a positive effect on his behaviour and challenging behaviour occurred less frequent.

Initially there were some questions as to whether he would benefit from this treatment. After all his behaviour had been the same for years and at the start there seemed to be some acceptance of the situation. However, in the course of the treatment everyone became more and more enthusiastic when viewing video images of the sessions. At the end of the treatment parents and caregivers were surprised and extremely satisfied with the results.

# 5 Who is the therapist?

**Marianne van Groenigen-Hulst**

I am a developmental psychologist and mental health psychologist. Since 1997 I have been working with people with disabilities, first as a caregiver and later as a developmental psychologist. My heart goes out to clients living in home care facilities who have a mild, severe and profound intellectual disability and additional problems. I enjoy working with children as well as the elderly. I have worked with different kinds of challenging behaviour requiring more specific treatment instead of ‘simply’ adjusting the caregiving style. Some clients have shown certain behaviours for such a long time and they are so deeply rooted that caregivers simply accept them as parts of the clients’ being. I have also encountered people who in the course of their lives have become increasingly restricted in their freedom or living space often leading to more challenging behaviour.

I started studying attachment intensively after coming across the research on attachment by the Vrije Universiteit in Amsterdam. Knowing as I do the prevalence of clients suffering from attachment problems, I am determined to help establish a secure attachment where possible. For me, simply diagnosing the problem is not enough! After following the basic course on attachment and supervision, I feel equipped to contribute to this issue in a positive way. Working with clients in a one-on-one setting enriches my work as a developmental psychologist hugely. This truly is a gift. I also enjoy discussing with others the different possibilities for treatment and other tasks. This keeps me focused and helps me reflect on myself.

**Mirjam Wouda**

I am a developmental psychologist and mental health psychologist at the same home care facility of Marianne van Groeningen-Hulst.
I followed the ‘Attachment therapy course’ and I am a therapist within the home care facility therapy department of the facility Ons Tweede Thuis.

# 5 Case Mary

**A fifteen-year-old-girl with a moderate intellectual disability**

***Mieke Hoenderboom***

## 1 Introduction to the case

### 1.1 Intake and assessment

At the request of a colleague, I read the report of Mary, a fifteen-year-old girl with a mild intellectual disability living in the home care facility where she has lived since she was about two or three years old. Before placement in the home care facility she lived with her mother and her younger brother. Her mother was single and had a substance addiction (alcohol). She could not cope sufficiently with the level of care needed for Mary and Mary was neglected. Over time, she was moved from one care home to the other, as the care she needed couldn't be provided. When she was about twelve years old, she ended up living in a group home within a large care home facility.

People often suspected that Mary might have autism. The caregivers of the group home did not manage to take care of her all in the same way, to create peace of mind for her. Sometimes they seemed to have found an adequate caregiving style, but when this turned out not to be the case Mary's behaviour would become aggressive. Her behaviour was described as 'chaotic'. For example, sometimes the caregivers of the daytime activities thought they had found a fun game for her because she had previously reacted positively to it, but after that she frequently didn't like it anymore and she would break material. The same was the case when walking together; the first times this worked out fine, but then later Mary didn't want this anymore. The caregivers tried different activities but nothing seemed to be a success for longer periods of time. Some caregivers thought that Mary had a particular connection with other caregivers but this turned out not to be the case either. Sometimes it seemed that Mary wanted to enter into a relationship with a caregiver, but then she would reject that caregiver by not cooperating or by hitting or kicking him.

It was difficult for caregivers to make contact with Mary. As soon as they would approach her, she would walk away and show aggressive behaviour such as: hitting, poking their eyes or face and scratching their hands. The caregivers were constantly alert to this behaviour and would avoid coming near her. Mary would get scared or over-excited if someone came too close. Because of the aggressive behaviour many people distanced themselves from her and she did not receive what she so desperately needed: contact and closeness. She became increasingly separated and isolated from her group members as a result of her aggressive behaviour and because, according to the caregivers, she was over-sensitive to stimuli. When the other clients were sitting at the table in the living room, she sat on the couch. The intensity of the challenging behaviour was high.

Mary showed aggressive behaviour several times a day. It was no longer possible for her to really enjoy herself and forget everything around. She always had her guard up. From time to time her mother came to visit with her guardian and her little brother. Her mother didn't seem to have real contact with Mary either. The caregivers indicated that she would react to visits but it remained unclear whether she reacted to her mother's presence specifically.

Mary wore pyjamas at night; a one-piece nightie with a zip at the back, because she would otherwise take her own clothes off. At first, I was not allowed to get too close to her in the therapy room. When I would do so, she would walk away or react aggressively. She would remove herself from the situation, but she would not run away from the building itself. She would often go to another place or room. She would look for places that were familiar and well-known to her, such as the playroom and the garden where she often played with sand and water, which she loved doing.

A disturbed attachment was suspected because of her troubled history. I carried out a diagnostic examination using the Clinical Observation Attachment (COA) and the List of Behavioural Signs of Disturbed Attachment in Young Children (BSDA; Boris & Zeanah, 2005; Zeanah, Mammen & Lieberman, 1993; Giltaij, Sterkenburg & Schuengel, 2017; Giltaij, 2017) in accordance with the description in Dekker-Van der Sande and Janssen (2010). The results once again confirmed the suspicion of a disturbed attachment. I started with the therapy when she was fifteen years old. This was the first time I conducted the ITAB treatment.

### 1.2 Preparation ITAB

The therapy sessions were held in the playroom where there was a mattress and also two skippy-sized balls. The room was designed with peace of mind and little external stimuli. We assumed that this was a familiar space for her and a well-known room in the house.
I wore appropriate clothing because she was physically very active.
I decided to wear glasses to protect my eyes from her trying to poke them when being agressive. I thought about how, as a therapist, I would be able to make contact with her from close by; putting on protective- or sunglasses seemed worth a try. Wearing glasses appeared not to be an obstacle to the therapy and she did not remove them from my face. The caregivers did not wear glasses as they stayed at a distance from her. The reason for this was that they were not able to make real contact with her anymore. Mary had no visual impairment and could therefore easily without hesitation, poke her right index and middle finger in the direction of someone's eyes.

The playroom was always available but not always clean. It was also difficult that the it had two entrances. Because of this I was never entirely sure if someone would come in from the other side during therapy. I wasn't too bothered by this but I noticed that Mary was. When there was noise coming from the hallway, she reacted very alert. I was then able to make sure that the second entrance was locked so that no one else could enter the room by accident.
The caregivers of the other group took little account of the therapy sessions; noises coming from the other hallway could not be stopped. Closing one of the doors however prevented unexpected situations.

## 2 ITAB therapy

### 2.1 Phase 1 Attachment Therapy

*Phase 1.1 Bonding - Making contact*

In October I started the first phase which lasted a long time. The sessions each took approximately 45 minutes. I often started with a positive activity, like singing a song together. At the beginning of the sessions Mary would first lie down on the mattress and then I would follow her by lying down as well, next to her. Then she sat down leaning against a ball and I would sit down against another other ball. Mary quickly realised that I was imitating all her actions. As soon as I got too close for her liking, she tried to poke my eyes or scratch my hand. This happened a couple of times. It was nerve-wracking for both of us to meet again after such a 'scratch incident'. She was very used to people staying away from her and keeping their distance when she showed aggressive behaviour. And here I kept coming back. When we were lying on the floor, Mary moved her leg towards mine and then I did the same. I would let my leg hang a little longer so that my foot touched hers. We often sat across from each other and she would move her hands forward. I imitated this. I didn't immediately pull my hands back but let them hang so she could touch them. In this way I tried to give her the opportunity to make contact. I waited for her to react. By doing this I tried to lower the threshold of contact for her. I also did this to see if she could touch my hands. In April (six months after the start of the treatment) I experienced the first real contact. She touched my hand with her finger, a gentle touch. This was a beautiful moment.

*Phase 1.2 Symbiosis*

When I came to the house, Mary said my name and walked into the playroom. Sometimes she would already be there because she knew I was coming. In this phase I tried to provoke her further by always waiting for her initiative to which I would react. When doing so, I tried to provoke Mary by waiting a moment to react, so that she could react again first. In this phase, Mary reacted more freely and unrestrainedly to me. She was very mobile and flexible. She could make crazy movements on the mattress. I tried to keep up with her movements but was not as flexible as she. For example, she managed to hold her leg against her face and I really couldn't which I mentioned to her. Then I often saw a smile, as if she said: 'Haha, you can't do that'. Despite the great flexibility in her movements, I tried to go as far as I possibly could in imitating her, mirroring her behaviour and emotions/mental state.

In this phase I brought toys to play with, such as a baby rattle, some cuddles and 'smurf snot' (liquid rubber in a jar). At first I wanted to do something with water and sand as she liked that very much, but this didn't seem very practical in the playroom. The liquid rubber you can slide through your fingers, squeeze it and it always stays in one piece. At first Mary didn't seem to know what to do with this material. The baby rattle made a sound and it could be spun around. She seemed to like this. There was no interaction when playing, she often simply pulled the toys towards herself. She didn't play a lot with the material. She was very busy with her own body, taking off her clothes, playing with her toes. It was very basic; it was all about physical sensations. During the day the caregivers were always looking for material she liked to touch and feel. It was a phase of discovery.

Mary had no particular curiosity about material. I went out of the room once to check on the video camera to see if she would do anything with them when I wasn't there. She then threw the materials that were in front of her to the side and did not play with them at all. I had brought hard, soft and squeezy toys but this didn't seem to make any difference to her. I tried to excite her curiosity by touching and feeling the materials together with our hands and faces and by holding on to them. I didn't get the impression that she really liked it or that she liked it enough to start playing with it herself. She enjoyed moving her body more, in which she would take the initiative and I then would mirror her sounds and movements. With these mirroring-games I often saw a smile on her face. I had the feeling that these were moments of real contact. I would describe (give words to/under-title) her behaviour and emotions as well as my own behaviour and emotions (where appropriate). For example: 'I see a smile on your face, you are enjoying it, aren't you, I am also enjoying our play'.

In this phase I was no longer wearing my glasses and the poking and scratching was greatly reduced. The tendency no longer seemed to exist. The caregivers of the home care facility indicated that Mary was seeking more proximity and contact on her own initiative.

*Phase 1.3 Stimulation to individuation*
The distance between Mary and me changed. She allowed me to get closer and she was relaxed when I left and returned. Besides mirroring her actions and emotions, we were also playing together. We could now sit closer together. During the first two phases we sat on the mattress facing each other with our legs stretched out straight ahead and our feet touching. At a certain point we were able to sit with our legs next to each other. That's how I came to sit next to her instead of opposite her. The first few times I did this, she very quickly went back to sitting across from me. Gradually she learned to trust me and I could sit next to her more often. There was a lot of taking turns during play, she tried to provoke more reactions from me by fooling around. Physical contact had been particularly difficult for Mary prior to the therapy. She seemed to find it very scary and nerve-wracking when people came too close. By adding contact-play I was able to find out how she reacted to the contact when I touched her and got closer to her. At the end of this phase Mary was able to stay in contact for longer periods of time and broke off contact much less often.

In the end I had brought other material with me, but even after offering it several times there was still no interest. She was however interested in contact-play and in singing songs. We always started the sessions on the floor, singing a song and we would always end with the movement 'done' (rubbing hands over each other). She listened to the songs. Many things were new as she wasn't used to playing or doing anything just for fun (making a sound with toys and singing a song). Up to now when someone made contact with her it had always been functional, such as changing her nappy when she was a child and giving her a bottle. There was contact with the caregiver only when it was necessary and this contact consisted of very limited interaction and attention for her as a person and for her mental state.

At the end of the first phase she was able to verbally indicate 'ready' when the sessions had lasted long enough for her. At the beginning when I left, I got the impression that in her experience I was simply gone. However, as time went on, she often said: ‘Bye, Mieke’ and would start waiving consciously. The caregivers regularly said that Mary seemed to like the sessions as she often asked them: ‘Is Mieke coming?’.

Over time, challenging behaviour at the home care facility became less frequent. Mary could now stay in the living room for longer periods of time without walking away. It was also less necessary to isolate her from the other clients. Mary became more involved in the living group. The caregivers of day care centre started to offer more variety in toys and materials. They saw that Mary did not reject this and seemed to be more open to it.

## 2.2 Phase 2 Behavioural therapy

I would stay in the living room for longer periods of time and would not go directly to the playroom with Mary. I showed that it was also possible just to stay in the living room. I deliberately entered into a conversation with a caregiver and she waited for me for a moment. Mary was able to stay seated for a longer period of time, she stayed longer in the living room and the daytime activities went better and better. She could now be in the living room and make more contact with the others around her. While Mary initially walked away when someone came too close, she was now able to stay seated when someone came and sat next to her on the couch.

I have carried out two ABC analyses: one with the caregivers of the home care facility and one with the caregivers of the daytime activity centre. I was more involved with the caregivers of the home care facility because the playroom where I gave the therapy was in her home/residence. I noticed that I could make the transfer easier by staying in the living group a bit longer and talking to the caregivers. The ABC analysis of the home care facility showed that Mary's restless behaviour had decreased. She could still show challenging behaviour in situations where when she felt trapped. This was the case, for example, with certain caring activities such as cutting her toenails. These were situations in which physical care needed to be given. The ABC analysis at the daytime activity centre showed that Mary was able to cope better; when someone entered the room she reacted less restlessly than before. Mary still reacted in an alert and restless way when another client or caregiver suddenly entered the daytime activity centre. However, it was easier for the caregivers to turn this reaction around and they were able to reassure her more quickly.

## 2.3 Phase 3 Generalisation

In order to make this phase as successful as possible, I used video footage to explain to the care team about attachment and the ITAB therapy. I educated them on what one could do, in terms of playing and engaging with Mary. The caregivers of the day care centre indicated that she seemed to be able to cope better; she reacted better to the presence of other people in the room. They offered different material. If the caregivers thought that she liked a certain material, they would also offer her one with a completely different feel. For example, when she seemed to like a cuddly toy the caregivers would experiment by giving her a rubber toy as well. After seeing the positive changes, they considered extending the day care hours for Mary.

At the home care facility there were regular moments when others were in the room or when it was very busy. Together with the caregivers of the home care facility, I checked whether Mary was still restless at the time, but this turned out not to be the case. We then tried to see if Mary would stay in the living room for longer periods of time.

We discussed what changes in the caregiver support would be desirable. Some caregivers immediately understood and implemented the transfer and the explanations accompanying the video recordings and changed the way they cared for her. Other caregivers sometimes stayed with their opinion and said: ‘Yes, she understands’ or ‘She does it just to annoy us’. I described the ‘Circle of Security’ and tried to increase the expertise of the caregivers and create a greater understanding of Mary’s behaviour. The caregivers all received training on attachment. I regularly helped them recognise certain of Mary’s behaviours shown in the training videos.

## 3 Completion

Major steps were made. Mary can now make contact without poking or scratching anyone’s eyes. It was very nice to be able to offer her the therapy.

The ITAB therapy requires a considerable investment of time on the part of the therapist; Mary’s course of treatment took more than a year. I noticed that offering the therapy can be intensive. I see that people/organisations can drop out in advance. That is why I think it is important that the care organisation concerned supports the therapy. Before starting the therapy, I asked Mary’s developmental psychologist if there was permission from the manager of the home care facility for the therapy. Providing good information from the start is essential. As it can be a long course of therapy, it is important that not too many things change during the therapy so that the client’s results can be attributed to the therapy and not to other factors within the care organisation.

Mary received one-on-one caregiving during the day. The location manager wanted us to reduce this because of the high costs. I noticed that not all caregivers were able to cope with this pressure. It made them restless and they therefore preferred to end this intensive supervision at the day care centre. In the long term however, the therapy can benefit the organisation and managers a lot with less overtime (costs) and sickness or overworked staff. Mary can now participate more in the group after the therapy; there is less stress at the home care facility as well as at the day care centre, which means that other clients also experience less stress. It contributes to a positive atmosphere and more overall satisfaction.

I think the home care facility profited more from Mary's therapy because she stayed at her home more often. Mary had daytime activities for two hours a day and the rest of the day she stayed at her home care facility. I had more contact with home caregivers. In hindsight, it might have been better if the evaluation moments of the therapy had been planned together with the home care facility and the day care centre, as these moments ended up not coinciding with each other. The caregivers of the living group and of the day care centre held the evaluations at different times from each other due to the conflicting schedules. Maybe, with a better planning from the start, evaluations could have been planned together.

Both the caregivers from the home care facility as of the day care centre noticed that Mary's 'poking behaviour' happened less frequently. Occasionally she was still restless, however the caregivers were now better able to regulate it for her.

## 4 Reporting to the client's relatives

On Mary's birthday, her guardian, mother and little brother came to visit. Usually Mary expressed aggressive behaviour towards her little brother. On this occasion however, that was not the case and everyone was surprised. Her brother said that Mary had changed and reacted more kindly. Although her mother visited Mary according to the visiting arrangements that were made, it was not possible to talk about the treatment in great depth. During the annual support plan meetings the treatment was discussed and evaluated. Her guardian was also present at this meeting.

# 5 Who is the therapist?

**Mieke Hoenderboom**

I am a developmental psychologist specialist working at ’s Heeren Loo in the care for people with intellectual disabilities. At the moment I am employed at an outpatient clinic and at a care farm for children and young people. I also work as a freelancer, carrying out various activities. I studied at the University of Applied Science in Haren and at the Rijks Universiteit Groningen (RUG), the Netherlands. During a bachelor’s internship, I started talking to a developmental psychologist and subsequently thought it would be nice to study Remedial Education at the RUG, which I ended up doing. After obtaining my master’s degree, I first worked in the north of the Netherlands and then in Twente in the east of the country. The subject of attachment has been my interest for many years and through my work I came across ITAB therapy. I followed the basic course in Attachment Therapy, and the subsequent moments of supervision as parts of the ITAB therapy training.

# 6 Case Limei

**An eleven-year-old girl with moderate intellectual disability**

***Henri Koelewijn***

## 1 Introduction to the case

### 1.1 Intake and assessment

It is Thursday afternoon. A consultation about Limei is held at the care organisation. In the meeting room, caregivers, a developmental psychologist, a CCE consultant[6], the GP and Limei's parents sit together to discuss a plan/the approach.

Limei has been living in this centre for a number of months now. The first months seemed to go well. It looked like Limei was adapting quickly to her new home. The caregivers described her as cheerful and spontaneous. But now, a few months later, the picture is different. The consultation was held to answer the question: 'What does Limei need in order to be comfortable and at ease again in her home environment?' Recently caregivers witnessed many incidents of aggressive behaviour and do not observe a relaxed and comfortable Limei as they knew her from the past. She avoids contact or shows aggression towards her caregivers. In addition to this physical aggression, she shows verbal aggression. She calls her caregivers 'A**hole*' and curses and shouts a lot.

The CCE consultant has just presented his report. He describes Limei as a girl with an insecure attachment development. The mother asks: 'Does the home care facility offer therapy for children with an attachment disorder?'

This case describes the course of ITAB therapy of Limei. After a brief introduction about Limei, each phase of the therapy is explained. The perspective of the text alternates between retrospectively describing

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[6] (CCE): A partner of healthcare professionals when expertise is needed on severe challenging behaviour for people who need long-term professional care and support.

what has been done and a glimpse into the therapy sessions themselves.

### 1.2 Preparation ITAB

When I met Limei, she was an eleven-year-old girl with a moderate intellectual disability. She was born in China and abandoned by her parent(s). When she was two years, a Dutch couple adopted her. It is not clear what exactly happened in the first months of her life. Her adoptive family observed a developmental delay at an early stage.

Limei lived in a group of eight children with intellectual disabilities and during the day, she attended a special school. She continued to go there even when she was not doing well. Miraculously, she never showed anger or aggressive behaviour at school. On the contrary, she paid a lot of attention to the teacher's stories, was very motivated and concentrated on her tasks and was helpful to other children.

I worked as a developmental psychologist within the home care facility where Limei lived. I was not involved in her home-/living group. I was asked to give Limei ITAB therapy.

Before starting the treatment, I needed more information about Limei's developmental level, background, course of life and behaviour. In the preparatory phase, I had contact with her parents, her GP, caregivers and I observed Limei in her home care facility. Together with her (adoptive) family and caregivers we decided how to explain the start of the therapy. We chose the term 'playmate'. All parties agreed that they would communicate with Limei that I would visit her as a playmate twice a week.

## 2 ITAB therapy

### 2.1 Phase 1 Attachment Therapy

The Integrative Therapy for Attachment and Behaviour consists of three phases. The Attachment Therapy Phase, the Behaviour Therapy Phase and the Generalisation Phase. These are described in the ITAB treatment protocol (Sterkenburg & Schuengel, 2020). This protocol has been adapted to meet the needs and wishes of people with moderate intellectual disabilities (Sterkenburg & Weijburg-Melis, 2017). Such adjustments include the activities carried out with game materials for example. In addition, the frequency of the therapy is twice a week instead of three times a week.

It is Wednesday. I am on my way to Limei's house. Parents and caregivers told her I would come to visit every week; on Mondays and Wednesdays. They showed her a picture of me and told her that I am her 'playmate' from now onwards. Today I will start the therapy. First, let's see if I can make contact. A caregiver opens the door and takes me to Limei's bedroom. There, she sits quietly awaiting my arrival. She shakes hands in a slightly uncomfortable way. The caregiver tells her that I have come to play games with her.

*Phase 1.1 Bonding - Making contact*
I ask Limei if she has any games. She takes me to the toy cupboard and shows me the games. I follow and react: 'Gosh, what a lot of toys you have! What game shall we play?' She quickly grabs three boxes and gives them to me and walks straight to the playroom. This is an unfurnished room on the first floor of the house. The room is almost empty. There is a cupboard and a bench with a side table. There is a rug with cushions. I ask her where we are going to sit. Limei refers me to the couch: 'You have to sit there'. She sits down on the rug and sets up the first game. She starts to arrange the toys enthusiastically. I verbally describe what she does and mirror her behaviour. In the meantime she keeps an eye on me and says: 'Stop it'.

In the first weeks I mainly mirrored and followed Limei's emotions and behaviour. I did this because, for the time being, I wanted her to take the lead; the focus was on attuning to her mental state; to her feelings and thoughts. I tried to mirror her behaviour without literally replicating it as I noticed this was annoying to her. So I adapted my reaction; changed the tone, as if I was summarizing something. Or I would turn it into a question. For example, if she said: 'I'm going to school tomorrow', I would then react: 'Oh, you're going to school tomorrow' - sometimes asking, sometimes as a statement. At that moment it was especially important not to see her as a 'source of information'. It was tempting to ask what she was going to do at school or what the teacher's name was. By doing so however I would be taking the lead in the conversation, as I really to wanted her to have this role. Also, I wanted to connect with how she experienced the world. She didn't have to connect with me or my interests and thoughts. She was the focus and so the goal in this phase was always to be aware of that. That way her existence was recognized with the message: 'You are here, you are meaningful, you have influence'. I wanted to attune to her mental state.

After a few sessions a pattern began to emerge. My arrival, twice a week, became predictable and familiar. My approach became familiar and safe. The contact was more relaxed and playing was more peaceful. A familiar pattern also developed within the playing itself and in the contact with her. However, this process of constructive contact was disrupted by a period in which she had a lot of stress two months after the start. I kept visiting and our pattern of play was continued. I did not observe much stress during the therapy sessions, but I did notice that the pace was quicker and the duration shorter. Limei was in a hurry in her play, fleetingly in contact. She wanted to go back to her bedroom as soon as possible. When there was more rest after six weeks, we could take another step in the contact. More and more often a kind of unity ('we') came into being.

It is now June, three months later. We are lying on our stomachs on the rug doing a puzzle. Without too many words, we manage to continue the game. She takes a piece; I take a piece. It is a familiar rhythm. We have done this before. Limei takes off her shoes. 'Take your shoes off, Hédi!', 'You want me to take my shoes off?', 'Fine, take them off'. She then takes my shoes off. I lie down again and pretend to be a bit stiff in my back. Promptly, Limei grabs a pillow and puts it beside my head. ‘Lie down for a moment,’ she says. At the same time she clumsily presses my head onto the pillow. ‘Ah, wonderful’ I say. Limei continues the puzzle in a self-satisfied manner. I keep lying down. A few minutes later the puzzle is ready, she tidies it up and picks up the next box. I sit up again and join her game.... ‘Monday you will come again’, she says to herself. ‘Monday I’ll come again’, I reply.

*Phase 1.2 Symbiosis*

During play we develop a certain cadence. Not a lot of explanation was needed to start playing and stay in touch. The communication became more and more intuitive. We intuitively understand each other’s tempo, distance and interaction. The video images clearly showed that the physical distance had decreased. Together we were focused on the game we were playing. Occasionally there was physical contact when she briefly touched my hand or arm.

During this period, we had to change playroom due to the arrival of a new resident. In the new room there was hardly any space for playing on the floor. It was used as a second living room and was furnished with a dining and sitting area. We were forced to play a game at the dining table and this proved to be a bottleneck. The table was literally between us. This room was also adjacent to the central hall, and the noise coming from there disturbed her attention and play. She became anxious and alert, constantly distracted and had more difficulty in playing and in making and keeping contact.

During the supervision we concluded that board/card games or puzzles were too complicated for her to participate in fully. She would make her own rules because she did not oversee the game and it was particularly demanding for her cognitive level of functioning. I wanted to reach feelings and emotions. From that time onwards I tried to introduce sensorial games, fantasy games and reading her stories.

We were able to use the original room again after the summer holidays. This was helpful and Limei took more initiative again. I brought new materials, such as ropes and sheets, to build a tent. This gave new information about her inner world: she didn’t have a working plan, she just started with the material she came across and then would get stuck. Subsequently she would ask for help and would move from a leading position into a following position. Always

just for a moment, because this caused a feeling of not having control over the situation and that made her feel nervous.
During that period I also tried to offer sensory play, however this only worked to a limited extent. She did not like to play with clay very much, and would handcraft only for a short period of time. I only caught her attention when it came to letters and names. She loved physical activities such as ball games. The game she made up was more l like a fantasy game with the ball than a ball game with rules. She would do a trick or laid out a course on the floor and I had to follow her. With this I could experiment with attuning or regulating; 'in-tune' and 'out-of-tune'.

Limei opens the door with a smile. Before she greets me, she looks into the bag I brought. 'Balls!' she notices. 'Look carefully, what else is in it?' Next to different kinds of balls, there is a foam dice, the size of a football. Once in her room, she turns the bag over and chooses two of the balls and the dice. I also brought three hoops. She lays the hoops down in the room, throws the dice, shouts out the number of pips. She bounces her ball the given number of times, and hops from hoop to hoop. 'Now Hédi!' she shouts and sits down in my seat and starts looking at me. I copy her exactly. She closely observes what I do. Then she makes up a new exercise, which I also copy. I deliberately do not do it correct, almost a bit clumsy. 'No, Hédi! Back!' I ask for clarification and start again, following her instructions carefully. Some time later, I [again] continue to not follow her instructions. After doing it wrong 'by accident' at first, I now make it clear that I want things to be different. That creates stress. She responds correcting me: 'Hey, that's not allowed, now go to the hallway!' The first time she interrupts the game and sends me to the hallway as a sort of 'punishment'. When I start listening to her again, we are able to resume the game. She has not yet managed to relinquish control. That is still too nerve-wracking for her.

*Phase 1.3 Stimulation to individuation*
During the stimulation to individuation phase I started playing hide and seek, not listening to her any longer or participating as I would want something different, 'you and me' and I started emphasizing my own opinion. In the beginning of this phase of therapy I was unable calm her down (co-regulate) in the playroom. When the stress in Limei became too much, she resolutely told me that I had to go home. She immediately started to clean up and left the playroom.

This sometimes already happened after ten minutes. I did not succeed in changing her mind. She wanted to go back to her room as soon as possible. Her room was the place where she felt most safe and where she could regulate her stress. At those moments I chose to finish the therapy session and to respond to her needs, in order to maintain the relationship of trust that we had built up. However, I would always describe her feelings.

At first she could not talk about her feelings. A few times this led to uncontrolled anger and aggression. She attacked me, but at the same time she let herself be stopped. The first couple of times the session would then be over. Later she could tell me what she would be angry about. 'I said that you can take the blue pawn and I the red pawn and you want red and you don't participate anymore', 'You're not listening, Hédi!' and I replied 'Oh, that's why you're angry, it's good that you tell me', 'Shall we make up for it?' We were then able to end the therapy well and later we managed to resume the game and regulate the stress within the contact. It was also striking that during this period she started speaking more and more in the first person; 'I want..., I want..., I have...'.

I am in the playroom with Limei and notice that she is restless. Her pace is high, her breathing is shallow, she talks loudly, in a commanding tone. I have brought a sheet of paper and want to make an outline of her foot with a thick felt-tip pen. I put the sheet on the table, but she grabs it and puts it in the bag and says: 'We're not going to do that!' I mirror her behaviour by saying: 'You put the paper in the bag, we're not going to draw. What are we going to do?' She picks up a puzzle, throws the pieces on the floor, and sends me to the side of the rug. 'You're not allowed to join' she says in a loud voice. I sit down and see what she's doing, but after one minute she tidies the pieces up without having played with them. She then grabs a board game[7] and says: 'I've got red and you've got blue'. To which I firmly reply: 'I want red'. She repeats in a loud voice: 'No, I have red, you have blue'. I turn away from her, sit down with my arms crossed and repeat: 'I want red'. Then she pushes the table several times, harder and harder against my back and throws the table over. 'Hedi, go home!' she then shouts. I turn around and say calmly: 'You are angry'. That's when the tension subsides and our contact resumes.

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[7] The Dutch board game: 'Mens erger je niet'

She is able to say why she is angry. First on high pitch, then a little more calmly. Meanwhile she tidies up. She is not able to resume playing, but she is able to regulate the stress somewhat by talking. We end with a handshake and discuss what we are going to do next time.

## 2.2 Phase 2 Behavioural therapy

An ABC analysis was carried out mainly as a result of Limei's inability to regulate stress and her excessive need to have control. When she was stressed she pressured others in a controlling way, she would then be very demanding. Others then had to follow her 'orders' or leave immediately. Usually she did not manage to regulate her feelings and would end up cursing or hitting and subsequently she completely would lose self-control. By helping her to better recognise and articulate her own emotions, and helping her to regulate her feelings, we expected her to regulate them better by herself.

In this phase of the therapy I started working on recognising her emotions in order to give Limei a better grip on her stress. I introduced the four basic emotions with pictures; I let her write the meaning below them. I also used the basic emotions as a theme in fantasy games. We played with cuddly toys, hats, different stories and role-play. In the beginning this was scary for her and it mainly happened on my initiative. Limei followed my example. After a few weeks, she took more and more initiative and showed fantasy stories; we built a small tent for cuddly bears and made a class out of cuddly toys.

I then started talking more and more about my own emotions. 'I'm happy today, I don't like this, it makes me sad', or 'You scare me'. Then I started referring to her emotions: 'I see that you are... looking'. Always formulating the sentence from my own perspective 'I ...'; to emphasise the way I saw things. As soon as she was receptive to this, I started to make a distinction between 'little' and 'much'. 'How angry are you? This much or that much?'

Her emotions slowly became more differentiated. They did no longer always overwhelm. She started being able to distinguish between her own emotions and those of others. She recovered quickly when she was momentarily out of balance. For this she still needed the help and support of an adult. As a result, play was increasingly used as a moment of reflection. She brought real events from her life into the games she would play. She organised information, processed it and subsequently regulated her stress regarding topics that were unclear, new or exciting to her.

## 2.3 Phase 3 Generalisation

In this phase, the aim was to transfer the acquired skills and the playing pattern to the team of caregivers and to integrate this into Limei's daily supervision.

It was clear that Limei was developing during this phase. Within the therapy she showed more and more attachment behaviour. This meant that she shared her experiences (shared attention), she shared her mental state, asked for clarification, took the initiative to play, took my hand and would then involve me in her play, showed emotions and articulated them into words, sought support in cases of stress and was able to recover during contact.

Playing afforded her a moment of reflection during the week. This way she was able to ‘communicate’ what was on her mind. Sometimes it concerned her parents’ holiday, other times the death of an uncle, the Easter lunch at school, or sometimes it was just about who was in her group that day. The moments of play helped her to organise and process information and regulate stress.

The team noted that their contact and relationship with Limei was changing. Without any judgement they voiced her behaviour and mental state. They gave her time to react and would then suggest that maybe she was asking for something. This helped her to become aware of her own behaviour as well as her thoughts and to organise them.

My proposal for the team was to work towards some more fixed ‘play’ moments in the weekly programme. During the ‘play’ the caregivers only follow the child’s lead. For example, after room time in the afternoon, at least twice a week playing one-on-one for about fifteen minutes. During these ‘play’ moments she would get the opportunity to talk, draw, write or act out her mental state (experiences, thoughts and feelings).

In the team meeting, two caregivers were appointed to start these ‘play’ moments. I formulated guidelines on one A4 page and agreed with the caregivers on moments where I would coach them. During these moments, caregivers would share their experiences. I tried to describe in words what they and Limei were doing and made changes as necessary. When things would go well, the number of caregivers who would ‘play’ with her would increase. This practise continues to this day.

## 3 Completion

It is difficult to establish objectively how the ITAB therapy has benefitted Limei. Together with the therapy, I have been part of Limei’s development for two years. A lot has been achieved; she has shown a lot of development, but can all this be attributed to the twice-weekly ITAB sessions? I cannot be certain of that. Several important people have also been involved during that period; for example parents, caregivers, teachers and speech therapists.

At the end of the course of therapy, Limei clearly showed a more differentiated mood. At the beginning, when stress increased, Limei's aggression towards parents and caregivers would be visible quickly in the form of swearing, kicking, hitting and pulling hair. She completely lost control over herself and withdrew into her room. After the course of therapy, when she was a little bit stressed, she managed to indicate that she found something exciting or that she did not understand it, before the stress built up too much. Caregivers could now also better interpret her signals. By talking about (mirroring) her behaviour and feelings and asking whether she had a question, she could usually, with the help of her caregiver, indicate what was bothering her by drawing it or writing down a few words. By helping her to organise her world, her stress could be reduced and she could continue her programme.

Aggressive behaviour and escalations had not completely disappeared. Limei still struggled during difficult times especially when the world returned to being unpredictable; for example during the departure of a trusted caregiver or the Corona lockdown period. She then experienced loss of control and confidence in her surroundings. At those moments old behaviour returned. However, parents and caregivers could now better cope with this. As a result, they would not 'act shy' and instead quickly come up with a plan of action aimed at restoring a more predictable world to Limei. The 'behaviour that was difficult to understand' was now understood. By connecting to Limei's mental state, it is now possible to reduce and limit 'challenging behaviour'. The therapy clearly has had a positive effect in various events. The twice-weekly sessions provided a safe place to express her thoughts and feelings. In case of stressful events, she was able to share her fears and thoughts during the sessions. She would do this in her own way: sometimes through a fantasy play, a story or drawing and sometimes through emotional behaviour.

During the course of therapy the concept of 'I' clearly developed. In the phase of individuation I strongly emphasised the difference between 'I' and 'you'. This has strongly continued. 'I' messages increased in her daily language. She clearly showed her own will first with support of an adult who would give words to her message. After a while it became less nerve-wracking when someone wanted something different from her or would have a different opinion. At the end of the course of therapy there was even some exchange of opinions between her and adults. In addition to being aware of her own will, she also got attention for the way others experienced the world. For example, she would ask what I had done during my holiday and listened attentively to it. She could also accept it when I wanted something different from her.

In addition, what struck me was that within the ITAB sessions I sometimes did not realise that Limei was going through a 'bad' period. At a certain point her clothes were lying in piles in the playroom and I saw that her wardrobe had been moved from her room to the hallway. At that moment however, I had not connected this to her behaviour. I made another remark about all those clothes in the playroom and thought it was clever that, despite all the extra stimuli, she continued to play uninterrupted. She told me that she was getting a new closet. I didn't ask about it and focused on the game we were playing in the here and now. Later I understood the reason; at that time she couldn't tolerate anything in her bedroom and had removed her wardrobe from her room. Apparently, the ITAB sessions were familiar and safe enough for her to continue therapy in that difficult period.

To me, a number of things have been important during the course of therapy. In the first place: the received supervision. By discussing video recording from the session, I was better able to understand Limei's behaviour and define it in a certain developmental phase. For example, when she grabbed my hand and took me with her, this was a clear step in the attachment phase. I gained such insights during the supervision. At the same time, I was able to discuss how and when I would take a following step to proceed the next phase. Another important event was a meeting with another ITAB colleague from another healthcare facility who had also given therapy to a client with a moderate intellectual disability. She made me understand that I should not see the child as a 'source of information'. This helped me in only following Limei's lead and not asking her clarifying questions. This prevented me from directing or taking over the conversation unintentionally. In the latter case, I would no longer fully be attuned to her initiative. This was particularly important however in building contact and trust.

Limei was my first ITAB client. I started this course of treatment with a very open mind, and without high expectations. Firstly I had no experience as an ITAB therapist myself and could not foresee the potential effects of the intervention. Secondly I did not want to put pressure on the process unconsciously so I limited my expectations. In spite of that, it has benefitted Limei, her parents and caregivers a lot. The process has been intensive; a one-hour session twice a week, every week. In addition, every six weeks there were also supervision sessions at the Vrije Universiteit, Amsterdam. This all added up to a considerable investment in time. I learned to start the therapy sessions without a planned scenario. Initially I had ideas about how the sessions should be organised, but I noticed that things always turned out differently. The more I could let go of that, the better I could connect. This turned out to be especially important in the beginning as from that moment of contact we could then develop a relationship of trust. Later on I started to consciously show certain behaviour, for example by indicating that I wanted the red pawn when she gave me the green one. I did this to help her practise regulating stress by using words.

## 4 Reporting to the client's relatives

I have held regular consultations with Limei's parents about the progress of the therapy. During these conversations we talked about video fragments of the therapy sessions. Her parents noticed how relaxed Limei had become during play and how free she seemed to be in our contact. In addition to what I had noticed, her parents were usually able to understand more of her behaviour during the sessions. They were also better able to understand what she was saying and could give context to this, particular events at school or in the family. For Limei's parents there was a clear relationship between her more preferred behaviour and a more adequate mood and the start of the therapy.

During the first consultation Limei's mother asked me whether or not I was afraid that Limei would hit me. I had not considered it as a possibility and had not felt threatened up to that moment. However, I then understood that Limei regularly hit or attacked her mother during that period. We then started to talk about 'giving her the lead' during the sessions; I would not want anything from her, I would follow her initiative and if she didn't want to proceed, I would stop with what we were doing. That gave the parents insights on how to react when they visited her at her home care facility. Usually they would have a clear plan. They would come to pick her up, engage in an activity and then they would bring her back and say goodbye a little later. During these visits, Limei regularly mentioned that she wanted to return to her home care facility. Her parents however then would describe what activity they were about to do next, which was well indented and had the goal of completing the visit in a positive way. In short, they prolonged their visits. The opposite happened: prolonging the visit often led to stress and Limei would get angry. After the therapy period, her parents became more relaxed about the visits. Not expecting too much and trying to respond to Limei's signals. They would make it clear that they understood her and that it was okey for them if she wanted to go to her care home or to her room, for example. This approach placed less demands on Limei and reduced the turmoil during the visits.

## 5 Who is the therapist?

**Henri Koelewijn**

I work as a developmental psychologist specialist at Amerpoort, a care facility for people with intellectual disabilities. I am involved in six home group facilities at the locations Christophorus and Nieuwenoord, where I mainly work with children and young adults with moderate to severe intellectual disabilities and behaviour that is difficult to understand. As a developmental psychologist, I am ultimately responsible for the provided care. I try to create a personalised treatment plan via multidisciplinary collaboration. The format of the plans we work with is tailored. For each client, we try to see what is appropriate to their needs and development and plan accordingly. The outlook and focus of the treatment is mainly on a healthy development and normalising their lives as far as possible. This means supporting a client in such a way that he can go to school or work, fill in leisure time, participate in a social life and maintain social contacts. The focus is not primarily reducing 'challenging behaviour' but to enrich the client's life, which usually leads to the fading out of 'challenging behaviour'. However, occasionally extra treatment is needed to remove strains in the client's development or to cope with trauma. In addition to my job as a developmental psychologist, I now work as an ITAB therapist for the Centre for Assessment and Treatment at Amerpoort. In Limei's case I was approached by the GP involved in this organisation. Together with the CCE, she thought that the ITAB treatment would be appreciated for Limei as ITAB is an effective treatment for the diagnosed disturbed attachment.

# 7 Different case examples

**Below Wendy Engelbertink provides a more general reflection on her ITAB experiences, supplemented with a number of short case fragments. These case fragments relate to different clients.**

***Wendy Engelbertink***

## 1 Introduction

### 1.1 Intake and assessment

A question many therapists have is: How does an ITAB course of treatment proceed within an organisation that provides care and support to people with a visual-and-intellectual or an intellectual disability? In this chapter I will provide more insight into the course of events within an organisation, on the basis of examples and personal treatment experiences.

Initially, the applications for ITAB arose mainly from the therapist's own caseload as a consequence of their focus on attachment.
In addition, the eligibility of suitable clients for ITAB therapy is reviewed, taking into account the therapist's own caseload. The focus on attachment amongst fellow developmental psychologist within the organisation has gradually expanded. This has required significant investments:

1. Study days were organised on attachment and assessment of attachment problems for developmental psychologists and caregivers throughout the organisation.
2. Intervision meetings on attachment were held for developmental psychologists and they would share case studies on attachment issues.
3. Feedback of results of the first ITAB courses of treatment, all were successfully completed, were given to caregivers and managers and the importance of the long-term benefits emphasised, for example less stress for the staff and financial advantages as the one-to-one caregiving was no longer needed.
4. In addition, a working group focusing on the theme of attachment was set up. This group consists of developmental psychologists who connect with the organisation's training officers, team leaders and managers specialising in the development of trainings

on assisting the process of assessment and treatment of attachment.

The developmental psychologist involved applies for the ITAB therapy for his client at an ITAB therapist. A brief description of the client is given; their problems, diagnostics and the therapeutic question. If the process of assessment has not yet been completed, the developmental psychologist of the ‘attachment’ workgroup completes the assessment. It is important to make a developmental anamnesis of the possible causes of the problems. Differential diagnostics between attachment problems and autism or other disorders should be carefully thought through in advance. The protocol (Dekkers-Van der Sande & Janssen, 2010; Giltaij et al., 2017; Giltaij, 2017) for the diagnosis of attachment problems should be followed as closely as possible. Once the assessment is completed, the level of care required for the client is examined. This indication is higher when a client displays severe challenging behaviour and shows a score of ‘3’ on the Severe Challenging Behaviour Consensus Protocol. This score indicates severe challenging behaviour. In addition, the contra-indications for the therapy in the client and his environment are examined. Reasons not to start the therapy are that the team of caregivers lacks a sensitive and/or responsive style of caregiving, is unstable in terms of staff formation and/or has too high staff turnover. In these situations, alternatives are explored to find solutions to these problems; what does the team need to achieve the desired level of sensitive and responsive caregiving in order to be able to offer the therapy and/or what can be done to ensure a more steady group of caregivers? Once this has been realised, the ITAB therapy can start.

## 1.2 Preparation ITAB

Our care organisation provides the therapy at our own location as part of psychotherapeutic treatment. Both resident and out-patient clients are eligible for ITAB. In practice however, the therapy is usually offered to people with an intellectual disability who no longer live at home. The location where the therapy is offered, can be either in the home care facility or at the day care centre or a combination of the two. However, it is essential that there is a room available that is not used by others during that time. This room should preferably be furnished in an attractive manner. The courses of therapy that have so far been completed, have used a playroom, an office, a room for relaxation and a private living room. It is important that while the therapy is held, the therapy room can be used exclusively by the client and the therapist, so that there really is time and space to establish and maintain contact; to initiate and build a relationship of trust, to focus on each other and to be able to work (together) with materials. The room must offer the possibility to focus on each other. In conversation with the caregiver, the client's developmental psychologist and possibly also with the client himself, we examine the way the client is able to make contact, with which game material he plays or uses and what other ways of making contact exist. However, the space is in principle accessible to everyone, such as for caregivers who would like to peek into the room, for example.

## 2 ITAB therapy

### 2.1 Phase 1: Attachment Therapy

*Phase 1.1 Bonding - Making contact*

The start of a therapy programme is always a bit stressful. It is important to form a comprehensive picture of the client after registration, intake and assessment. At the start of the ITAB therapy, it is important to pay attention to develop a ritual that suits the client and to make contact. When making contact, you mirror the client's behaviour and mental state as much as possible. This can be done by adopting the same posture as the client; making the same gestures and sounds; repeating words (or sounds if the client can't speak); and giving words to possible feelings. Video recordings of therapy sessions offers the possibility to look back at the moments of contact and the way they went. The advantage of video recordings is that development in the contact moments as well as pleasure can be better observed.

**Case Megan:** With Megan, a client with a moderate intellectual disability, we walked a lot in the first phase of the therapy. For her, this was an important way of dealing with the stress she experienced in contact with another person. This was also an important intervention in the home care facility in order to reduce any stress. During our walks we were able to walk close to each other, arm in arm, so Megan could better accept my proximity. Walking was also a nice way of mirroring: we would walk in the same rhythm and I repeated her words many times.

> Gradually our walks became shorter and the time in the therapy room longer.

Sometimes it is quite a challenge to connect with the client in the first phase. The trick is to let go of your own ideas; whatever it is that happens just let it happen and then look for possibilities to build up contact. Then further develop this contact and position yourself in a following and mirroring way. By looking back and reflecting on the video recordings, the intervention can be refined and tailored to the client without deviating from the treatment protocol.

> Importance of reflection: 'What I experienced as being a bit difficult, is when a client repeatedly keeps withdrawing from contact. The possibilities for contact then become less and can lead to me feeling powerless as a therapist. Moments of reflection and supervision have helped me to place the client's behaviour in the correct context and to anticipate it. Looking at the "Circle of Security" together with someone else and trying to recognise the client's behaviour in it, helps me finding an answer to the behaviour and the needs behind it'.

*Phase 1.2 Symbiosis*
In the phase of symbiosis playing and having fun together is a special experience. 'In-tune/out-of-tune' plays a very important role in this phase. It requires a high degree of sensitivity and responsiveness on the part of the therapist.

> Experience: 'Each time, I have experienced that the phase of symbiosis is relatively short compared to the other phases of the therapy. In my opinion, moving together and being in-tune/out-of-tune is an extremely powerful intervention that works on a deep level of consciousness. Without using words, the client's smallest signal is converted into a sense of influence based on experiencing, feeling and being together. The functional moment of stress and then experiencing the safe haven in the form of the therapist's response provides an enormous boost of relaxation and pleasure in that moment'.

**Case Joliet**: In the case of Joliet we arrived in this particular phase during Christmas. Throughout the sessions we had been rocking back and forth to the rhythm of Christmas carols. I experienced a beautiful playful interaction and I thought this was appropriate for the time of year: searching for connection and finding it. I was genuinely happy for her that she had re-established a connection with her parents during that time and wanted to go home for Christmas on her own initiative. Up to then, going home had not been a possibility for a very long time because of the challenging behaviour she showed. On the one hand it was a bit nerve-wracking for her to go home and on the other hand it was pleasant to be able to go home again. The visits to her parents, including staying the night, continued in a positive way afterwards.

*Phase 1.3 Stimulation to individuation*
During the phase of individuation, fun and special variations of activities can be used. This depends on the preferences and abilities of the client.

**Case Joliet**: Joliet liked to colour, dance, make music, play memory games and dominoes and participate in a fitness tv show called 'The Netherlands is moving'.[8] I enjoyed observing that her interest in different activities continued to progress. I also saw a development from 'doing something together' to 'wanting to do it alone' during the therapy sessions. I sometimes had thoughts and feelings such as: 'What am I doing here? I am no longer needed'. However, this would not entirely be the case: even though I was not always doing something special, being present in the room and being together, where my attention was unfocused and I stayed available, definitely stimulated a feeling of security for Joliet in exploring and in providing the safe haven when needed. Incidentally, I have also interpreted that as a sign that the therapy was coming to its end and I could consider moving towards the phase of transfer and generalisation.

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[8] 'Nederland in Beweging'

In this phase you also start breaking off and reconnect: you observe and experience the way a short separation and the reconnection takes place. Sometimes this is prompted spontaneously by the situation itself, and other times deliberately.

**Case Martin:** I deliberately only put one chair in the therapy room, so I had to go outside to get another one. The video recordings showed that Martin then had continued with his activity and he also re-established contact with me, the therapist, once I had returned and we could resume playing together. These are real moments of success for the client as well as for me, the therapist.

*2.2 Phase 2 Behavioural therapy*

This phase focuses on learning desirable behaviour instead of undesired behaviour. This means that certain undesired behaviour still occurs at critical moments for the client. By properly mapping out when this happens, therapy using positive reinforcement can teach the client new desirable behaviour. As a safe and trusted person, the therapist can help regulate stress (co-regulation) to create space for the client to learn new behaviour. However, this can also be a nerve-wracking phase.

**Case Meltem:** In order to connect to the situations where undesired behaviour still occurs, it is necessary to create these situations within the therapy as well. The therapist can consciously create situations which are stressful for the client and evoke the undesired behaviour. For example, it was difficult for Meltem to speak more quietly. She was often told: ‘You don’t have to shout like that’, ‘I can hear you’; or when she wanted to cuddle: ‘Can it be a little softer?’ For Meltem, this, in turn, caused stress. In the therapy we practised throwing balls: either throwing hard or soft; throwing at a target by staying within particular lines or trying to hit a point on the wall. This also caused a lot of noise and I subsequently received help from a colleague who came into the room for a moment to say that she was bothered by it. This caused Meltem a great deal of stress, but by articulating her emotions into words (mental state), my observation of her emotional reaction, space was created as well as relief: ‘It frightens you that she is bothered by it’. Meltem could agree and that made her feel seen and heard with regards to the stress she felt. Together, we were able to find a solution: we would announce in advance that we were going to make noise for about ten minutes.

Importance of supervision: ‘As a therapist, I was very upset that I had to do something with the client that was nerve-wracking for her. It felt like provoking certain behaviour, while the aim of the entire course of therapy is precisely to reduce disruptive behaviour. Could this endanger the attachment relationship that had just been established? This was a point of discussion which was dealt with extensively during the supervision, in which I was also able to express my own feelings of concern. The most important thing I have learned from this is that you are indeed supposed to consciously look for a stressful moment to then ‘learn’ new behaviour, while keeping a stable basis for a secure attachment with the therapist. The attachment relationship that has been built up can cope with this. The client knows where the safe haven is and that it remains available. It was an eye-opener for me to experience that all the elements in the “Circle of Security” are needed in order to develop a secure attachment. The moments of stress were therefore also very important for the client to experience: the safe haven exists and forms a buffer to which the client can always return to in times of stress. This has really helped me to look for stressful moments for the client because in the end this helps the client to deal with stress and learn an alternative desirable behaviour instead of undesired behaviour.’

It is important to make a good behaviour analysis in order to carefully consider which alternative behaviours are feasible and desirable in practice. It is therefore important to discuss this with the developmental psychologist of the home care facility and the caregivers.

# 3 Completion

Clients who received ITAB therapy have all shown strong personal development. This has resulted in more control, a greater variety of enjoyable activities and improved emotion regulation compared to the period before treatment. Caregivers have become more knowledgeable about emotion regulation and are more aware of the priority in a situation that could potentially escalate. Initially, that priority was still focused on the challenging behaviour. As caregivers became more aware of this and gained more positive experiences, the priority shifted to regulating emotions and learning new behaviour. Caregivers benefitted from support in differentiating emotion regulation and 'normal upbringing'. Rules, boundaries and frameworks remained important and could be enforced in a calm and clear manner. However, when a client's emotions increase, it is important to regulate them in order to then continue to offer the rules, boundaries and frameworks in a peaceful manner. In addition, caregivers also have emotions that should be regulated. Some caregivers are able to manage them better than others, but it often helps when you, as therapist/treatment coordinator, can support this emotion regulation. Providing psycho-education can be supportive and helpful.

**Case Joliet**: Joliet was caught in the living room while she was scooping out a full jar of peanut butter. Of course, the caregiver on duty started with highlighting the rules and expectations: 'Hey, what are you doing there?! That's not allowed!' The caregiver's reaction stemmed from a kind of astonishment at what was happening but was experienced as a punishment by Joliet. Joliet became stressed and started crying. She didn't know what to do except panic. The caregiver saw how her reaction affected Joliet and now knew that setting rules and expectations was counterproductive at that moment. Now the first thing to do was to regulate emotions: to mirror the stress reaction and mental state, stay calm and take time to calm down together again. When Joliet had calmed down again, the caregiver could re-establish the boundaries and frameworks in peace. In situations in which a client shows challenging behaviour, the goal of the intervention can sometimes be to rapidly switch to regulate emotions first after which boundaries can be set and then propose/discuss an alternative solution.

## 4 Reporting to the client’s relatives

Not only the feedback from the therapy to caregivers and relatives of the client is important. Reflecting on how the treatment went, is also essential for follow-up courses of treatment.

**Practical experience**: ‘I have often received positive feedback from caregivers and parents. This was a beautiful thing. For example, a caregiver said goodbye to the living group to pursue other ambitions, and she told me that she had benefited a lot from what I had told her about regulating emotions and promoting more appropriate behaviour. She often applied it to situations at work and also with her own children. That really gave me energy! A great compliment came from parents: “We are so happy that our daughter wants to come home again and that we have a *homely* atmosphere when she is at home.”’

## 5 Who is the therapist?

**Wendy Engelbertink**

I am a general health-psychologist and ITAB therapist at De Twentse Zorgcentra, the Netherlands. In 2005 I graduated as a developmental psychologist at the Vrije Universiteit in Amsterdam, where the research programme at the time was focused on attachment. For my graduation master thesis, I did a partial study on the effects of ITAB on the degree of proximity and contact seeking and the degree of stress in young people with severe intellectual and visual disabilities and disturbed attachment. In 2019, I became a mental health psychologist. Within De Twentse Zorgcentra, I am particularly focused on the theme of ‘attachment’.

# Conclusions

For all children, a secure bond with their parents promotes a healthy socio-emotional development. Naturally, this also applies to children and adults with a visual-and-intellectual or intellectual disability. When a child or adult with a visual-and-intellectual or intellectual disability feels safe, he can develop his own abilities in a positive way and learn to regulate his own emotions. However, not all people with visual-and-intellectual disability or intellectual disability have a secure attachment relationship with an attachment figure. This can result in severe challenging behaviour and/or self-injurious behaviour. For this group of people, the Integrative Therapy for Attachment and Behaviour has been developed. In this therapy, the attachment therapist will enter into an attachment relationship with the child or adult with a visual-and-intellectual disability or intellectual disability for the first time, or re-establish it. Through the attachment relationship, the client learns to regulate stress and reduce or eliminate challenging behaviour and self-injurious behaviour. A phase of generalisation follows, which focuses on adequate sensitive and responsive treatment of the caregivers involved on a daily basis (parents, caregivers of the home care facility or daytime activity centre).

Part 1 of this book describes the goals and secondary goals of the intervention. In addition, we provide more information on the intervention. We refer to publications and outline efficacious elements of the treatment. This text has also been offered to the Dutch Youth Institute (NJI) for re-registration of the intervention within the NJI database.

In Part 2, practical examples are given by seven therapists who give the ITAB in practice. These examples provide the reader with insights into different treatments. The described treatments concern the following:

1. A young adult woman with visual-and-motor impairment and severe intellectual disability.
2. A 9-year-old boy with severe intellectual and multiple disabilities.
3. A woman, blind and with a severe motor disability and severe intellectual disability.
4. An adult man with a severe intellectual disability, epilepsy and a nformation processing disorder.
5. A fifteen-year-old girl with a moderate intellectual disability.
6. An eleven-year-old girl with a moderate intellectual disability.
7. In the final chapter several cases are discussed to present insight into the different courses of treatment.

# Glossary

**ABC-analysis:** *Antecedent Behaviour Consequence.* This is an analysis of the client in a certain situation to gain insight into his challenging behaviour.

**Activity centre:** this is a wall playing board consisting of separate boards with different playing functions that stimulate dexterity, fine motor skills and eye-hand coordination.

**Centre for Consultation and Expertise (CCE):** a partner of healthcare professionals when expertise is needed on severe challenging behaviour for people who need long-term professional care and support.

**Co-regulation:** some clients with intellectual disabilities are not (yet) able to regulate their emotions entirely on their own. They depend on their parent/caregiver to 'co-regulate'. This means that the parent/caregiver regulates/guides the emotions for the client so that the client learns how to calm down themself.

**In-tune/out-of-tune:** this means that the therapist briefly stops a certain action (e.g. singing, reading out loud) and waits for the client's reaction before resuming the action. The client's reaction can be a small signal such as a glance, a sound, the search for eye contact or a touch. In this way, an attempt is made to strengthen the client's initiation, direction and contact.

**Joint attention:** this is a precursor to mentalisation. The client and the significant other (parent/therapist) are focused on a third object together. The client learns that when the therapist points his finger, it is not about the finger, but about what is pointed out, for example an animal in the petting zoo. This helps the client to see multiple perspectives, both of himself and of the other.

**Modelling:** a method of learning to imitate someone else's desirable behaviour and make it your own.

**Severe Challenging Behaviour Consensus Protocol** (in Dutch Consensus Protocol Ernstig Probleemgedrag; CEP): a protocol describing how the challenging behaviour of the person with an intellectual disability can be assessed.

**Symbiosis**: this refers to the breaking and subsequent restoration of the client's contact with the therapist. When the client has broken-off the contact with the therapist (for example by pushing the therapist away), the client can take more initiatives to re-establish contact with the therapist. The client can do this by getting back in touch with the therapist. The therapist then reacts positively to this, which offers extra reinforcement and acceptance.

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