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### ATTACH Protocol

#### *Philosophy:*

My practice, Southeastern Counseling Center, is dedicated to the health of families in the community. The focus of treatment is on disrupting unhealthy inherited family patterns and helping clients design a new future. I take a family systems approach in all my cases, based a thorough assessment, family genogram and gathering of historical information. Attending to the issues of attachment is an important part of that process, as well as identifying the family story/narrative that keeps the history of trauma and unhealthy family patterns in place. With regard to individuals with attachment problems, there are gaps in their stories or narratives (like Swiss cheese) which impede the sense of continuity and chronology of their lives. Whether or not they are experiencing implicit or explicit memory, they are living at the full affect of their past. It's not so much what happened, but what is held in memory and the age-old interpretations and meanings that sustain the emotional remnants of trauma, neglect, abandonment or abuse. Their stories or narratives of victimization precede everything they do. I help clients face their past in such a way that heals them from the past and subsequent breaks in attachment, thus enabling them to make new choices in the future, as well as alter their sense of history.

In addition, I ascribe to the entire mission, vision, and philosophy of ATTACH, as well as ATTACH's white paper on coercion. "ATTACH believes the proper use of therapeutic confrontation and other directive techniques may be beneficial but must be done in a manner that promotes attunement, sensitivity, and developmental appropriateness." The white paper further states that "research has shown that children learn best during times they are regulated (e.g., when the child is in a calm, receptive state) (Schoore,

2001). It is important to support and promote children's regulation during interventions. If a child becomes dysregulated, attempts should be made to restore regulation as soon as possible (e.g., a parent might actively assist the child in regaining a calm, receptive state by soothing the child and making sense of the experience).

In the past, attachment work/therapy has been associated with more aggressive and confrontational techniques, some of which were misused and led to the deaths of children. Unfortunately, this gave our work a bad name and caused others to view what we do in a more scrupulous manner and to question some of our basic premises. We have learned that providing an atmosphere of safety and security and helping children relax their minds is more effective than intense confrontation or coercion. Forced holding is not a method that is used in my practice. Every effort is made to create an environment of safety and security for the child. Safe containment is used only when the child becomes physically aggressive, kicking, biting, scratching, etc., and only for as long as necessary to help the child regain self-regulation. The child is never intentionally provoked into such a state. Rage therapy is never used in my practice. The child is told that we will deal with four basic feelings to begin with in treatment: mad, glad, sad, and scared. How we deal with those feelings is, "I'm mad because, I glad because, I'm sad because and I'm scared because." The child is told that giving up their feelings to their parental figure or caretaker keeps them from having the burden of carrying those feelings around with them. Techniques are taught and tools provided to help calm the child and manage whatever level of feeling that may arise. The principle of the critical window is strictly adhered to in my practice.

I share ATTACH's commitment to "educating the public about attachment issues in order to improve both prevention and treatment efforts," as well as "recognizing and promoting healthy attachment and its critical importance in human development." In fact, the sum total of my professional experience reinforces and sensitizes me to the importance of attachment in human development. In September of 2004, I traveled to Ecuador for 10 days and worked with 25 mothers and their children from a poor barrio in Manta. I have a substantial caseload of Spanish-speaking families, both documented and non-documented. The importance of attachment in human development is cross cultural and goes beyond regional boundaries. This therapist does

attachment work in both English and Spanish. Fostering attachment among children strengthens communities and helps children connect with their families and the outside world in an authentic manner. As a Spanish speaking attachment therapist, my practice is dedicated to bringing this work not only to citizens of the US, but also to the Spanish-speaking community, both here and abroad. This is my way of promoting world peace. This is a life long mission which I will carry into my retirement years.

One of my newly developed concerns has been for the fair and just treatment of undocumented immigrants. This is very much relevant to the field of attachment. ICE (Immigration and Customs Enforcement), once known as the INS, has become quite aggressive and proactive in apprehending, arresting and deporting undocumented immigrants. My concern is with the manner that families are treated and traumatized by ICE techniques. More and more predawn raids are being conducted in almost Gestapo style fashion, breaking up families, separating parents from children, and contributing to attachment problems among this vulnerable population. In certain instances, the actions of ICE are tantamount to child abuse. In one North Carolina raid on workers from the Smithfield Meat Packing Plant, ICE workers were accompanied by local DSS workers and threats were made to have children removed from the home if targeted persons did not cooperate.

***Target Population:***

Nearly three-quarters of my caseload involves treating children, adolescents, and their families. My focus over the past 15 years has been primarily on serving the 0-10 age group, largely because of my own children: twin girls who are now 17 years old. However, I continue to work with older adolescents as well, which has been my specialty for the past 30 years. In addition, I do extensive work with adults with attachment problems.

***Level of Practice:***

A therapist with broad training and experience, a majority of which is in attachment, who sees clients with mild to severe symptoms, and uses a variety of techniques and modalities, some of which are advanced, for treatment. Over the past 2 years, I have incorporated the use of EMDR in treating the long term effect of trauma and neglect, as well as other

disturbances from the past. While I treat a wide assortment of problems in my practice, the greatest focus is working with both children and adults with problems in attachment. Over the past 5 years, my practice has grown significantly in this area. Families travel from miles around to seek out my services.

***Program/Practice Overview:***

The bulk of my services are office-based, although I do provide some therapy in the home, especially in more intensive cases.

My general areas of specialization are:

- 1) **Adults**, with emphasis on anxiety, depression, and stress management issues.
- 2) **Adolescents and their families**, with emphasis on family therapy. Have run adolescent therapy groups in numerous clinical settings.
- 3) **Children, 12 and under**, with particular emphasis on attachment and bonding work. Also, help children express a variety of feelings through play therapy, role-play, drawings, and story telling.  
**Perform Child Custody Evaluations.** Write court reports and serve as expert witness in child custody situations.
- 4) **Substance Abuse Counseling.** Southeastern Counseling Center is licensed by the NC Dept. of Facility Services to provide outpatient counseling to **CD Clients**.
- 5) **Premarital and Marital Counseling**
- 6) **Eating Disorders** (a family approach).
- 7) **Family Violence Cases**
- 8) **Sexuality and Sexual Identity Issues—Gay and Lesbian Issues**
- 9) **Also have a wide range of experience dealing with clients with other Axis I Mental Disorders, such as Bipolar, Borderline Personality Disorder, and Schizophrenia.**

***Intake/Admission:***

**A. Intake/Admission Process**

I use a standard **intake data sheet** for completing an intake on all of my clients. It includes demographic data, addresses, phone numbers, presenting problem, family composition, income, previous treatment, insurance information, and any other information necessary in judging the

appropriateness of a referral. In the case of certain managed care companies, specific paperwork is required or utilized for both the intake and assessment process, but I always think in terms of my own intake and assessment and try to cover all the bases no matter what format I'm using. I receive referrals from managed cares, insurance companies, The Guilford Center, church organizations, EAP's, the Yellow Pages, the internet (ATTACH and Nancy Thomas's websites), mental health centers, schools, and other satisfied clients. I take intake information from clients over the phone before meeting with them the first time. Sometimes, questionnaires are sent out ahead of time, especially when attachment problems are indicated, so that I have the maximum information possible before opening the case. If I feel I am not qualified or experienced enough in dealing with a particular issue, I would refer the client to another therapist or agency. For instance, I don't do intensive work with sex offenders. Therefore, I would refer those cases to someone specializing in that area. Also, I am not equipped to deal with actively suicidal people. If preferred a client may be referred to a female therapist.

***Assessment:***

The **last 3 pages** of my standard **intake data form** are used to complete the assessment. This includes initial goals for treatment, mental status, family history, drug and alcohol history, medical history, suicide and homicide risk assessment, physical and sexual abuse history and other relevant factors. I supplement the drug and alcohol history, when substance abuse is the primary problem or when doing a D.O.T. evaluation, with the **TAAD (Triage Assessment for Addictive Disorders)**. In the case of attachment, other tools are used to supplement the basic assessment, such as the **RADQ, developmental history, child's biography and parent's biography**, or the **Life Script** by the Evergreen Psychotherapy Center. Furthermore, I sometimes use the subtests in the **CHAFCA Manual (Cline/Helding Adopted & Foster Child Assessment)**, especially the subtest related to sexual abuse.

However, my most effective method of assessing an individual or family is the taking of a family genogram, which is generally completed by the end of the second session. Whatever may have been missed during the completion of the initial assessment is elicited and uncovered during the genogram process, including information about a person's attachment history. I try to

ask questions that will fill in gaps in a person's biographic data, as illustrated in my questionnaires. I'm interested in uncovering the unhealthy inherited family patterns in the family and gleaning the family story; that is: the interpretation or meaning that the person or family puts on past events, keeping the cycle of trauma or break in attachment in place. The mere taking of the genogram in this context, often shifts the narrative in a healing way. This is a fairly non-threatening process that allows family members to make connections they haven't seen before and it is common for details to surface that were originally missed in the initial interview, even with regard to issues or problems the client identified as not being relevant at the beginning of the assessment.

### ***Treatment Planning:***

My first step in contracting for treatment is having the client or guardian sign a **consent for treatment**. It addresses what to expect in treatment and has a section on the limitations of confidentiality. It also allows this therapist to communicate with a particular managed care, insurance company, or mental health authority involved in the referral. They also receive a copy of my HIPAA privacy notice. In addition, I have each client and/or guardian read and sign a **statement of understanding**, which gives further information on services provided, the assessment and treatment planning process, confidentiality, and mutual expectations for treatment. Since I serve Hispanic clients as well, I have translated both documents into Spanish so that there are no misunderstandings with my Spanish-speaking clients.

The next step is to establish a treatment plan based on identified problems during the intake and assessment phase. In addition to forms sometimes required by respective insurance companies and managed cares, I have a **treatment plan form** that I consistently use in most of my cases. The first page is a **diagnostic face sheet** that includes identifying information, family stories that were uncovered during the assessment and genogram process, DSM-IV Diagnoses, long term goals, client strengths, and estimated length of treatment. The second page is broken up into 3 main sections: **problem description, goals, and objectives**. The goals are stated in specific and measurable terms. Progress toward these goals is reviewed on a periodic basis. The treatment plan is the foundation for treatment. It clarifies what needs to happen for change to occur, as well as who is involved and what

their role is in the treatment process is. Both this therapist and the client(s) sign the treatment plan, making it a contract for how treatment will occur and what our direction will be. If I am dealing with a minor, the parent or guardian signs the treatment plan, as well as the minor himself. I feel strongly that the child needs to buy into the contract in some way and thus his/her input is always included. At times, case managers, guardian ad litem, probation officers, and other adults or professionals significant to the child are included in the treatment planning process and also sign and approve the treatment plan.

My basis for soliciting the child's cooperation in treatment, especially in attachment cases is asking him the six questions (Forrest R. Lien, LCSW- Institute for Attachment and Child Development) which serve as the basic contract.

- a. What happened to you in the past?
- b. How have your past experiences affected you?
- c. How is your life going now?
- d. How will your life be in the future if you do not change?
- e. Are you willing to do what it takes to improve?
- f. Are you willing to accept the rules of therapy?

I periodically ask these questions again when I see the child's investment in the treatment process waning. I will sometimes fire the child from treatment (on a temporary basis) until he/she can recommit to the treatment process. [I will continue to work with the parents while the child stewes about the situation]. I find that this has a disruptive and paradoxical effect on most children, as they do not want to be excluded from what's going on.

Other contracts are necessary when holding therapy is involved, such as the **Hold-Harmless agreement** that I have parents sign when there is a possibility that I might have to touch their child, and the **family intensive contract** used when doing intensives.

***Treatment techniques used:***

The work I do is more than just "talk therapy." After gleaning the family story, identifying the historical events that impact the child, and pin pointing the narrative keeping the trauma in place, I can then do the work of

treating the trauma and dealing with the impact. I call this treating the family story or the "story of attachment." This involves reframing, debriefing, revisiting and at times reliving traumatic events, but within the context of the safe-container created by the therapeutic team (therapist, parents, and caregivers). This is an intimately interactive and experiential process that can be a painful, even for the caretakers, but when completed, helps the individual heal from the past and create a new life. This is not "retraumatization," but a working through of past hurts with the least amount of stress on the child. It is done in a rational, safe, and compassionate manner that leaves the person whole and complete and able to go on with his/her life. The goal is a close, intimate connection with the caretaker (mother/father/foster parent, etc.), who is able to absorb, accept, and help modulate the child's feelings from the past. It is a process of attunement that binds the child and the caretaker together in a lasting and reciprocal way. Much of my work in healing the family story resonates with the work of Denise B. Lacher, Todd Nichols and Joanne C. May, which is described in the publications **Parenting with Stories** and **Connecting with Kids through Stories**. The parents/caretakers are used to redefine the child's life, past and present, and create a new context for the future. Story telling and retelling is an important part of my work.

Healing the story is effective because all traumas and past hurts occur within the context of language and it is difficult for the individual to remember things before language. Altering the story or narrative alters history, as most hurts live in memory. Yet attachment work is not simply a cognitive process. We are triggered by sensory memories as well. These can be accessed and healed through the interactive and experiential process of attachment work, even for children with low cognitive skills.

Simultaneously, the parents are taught the basics of attachment, e.g. the common sense things that parents do to connect with their child, in "utero" and during the first three years of life. They are taught the language of attachment and attunement that healthy mothers develop early on in a child's development. Parents are taught the importance of touch, motion, eye contact, warmth nurturing, good diet, humor, play, curiosity and providing a safe environment, where the child feels safe, secure and accepted. They are taught the importance of compassionate and strong limit-setting and consistency. Behavior issues are addressed and pitfalls of

the parents' present responses to the child examined. However, the parents are never treated in a judgmental fashion, but rather as key members of the team. The message from the mom or primary caregiver is that "I am big enough, strong enough, smart enough, and willing enough to care for you no matter what!"

I also use "parts work" as presented by Holly van Gulden and Kenny Miller as a useful tool in dealing with trauma. It allows the stronger and better parts of oneself to intervene when more negative feelings arise. I am beginning to use this with both adults and children dealing with posttraumatic stress. I also make use of life books and autobiographies, especially with filling in gaps in the narrative.

Treatment always includes a review of the parents' attachment issues, especially in relation to how they parent their child. We tend to parent the way we were raised and not in some new and transformed way. Thus parents need compassionate help in disrupting the negative patterns they have inherited from their parents, as well as breaking the cycle of hurt and pain. Addressing the parents' attachment issues makes children get better, even if they are not in the room. I spend as much time dealing with parents alone as I do in sessions with the child.

Parental and caretaker holding is often key and necessary to my work with attachment disordered children. As the therapist, I never do the holding myself, as it interferes the parent or caretaker gaining the attachment with the child. I agree with Gregory C. Keck that holding the child or adolescent results in an intensity that cannot be duplicated in any other therapeutic format. He has stated that "therapeutic holdings - not restraint- mobilize development." It produces emotional responses that are unlikely to occur in any other kind of therapeutic intervention. As stated earlier, no coercion is involved and the holding is used in conjunction with other techniques, such as EMDR.

***Safety/risk management plan:***

I go by and accept ATTACH's guidelines and principles for "monitoring and safeguarding the psychological, emotional, and physical well-being of everyone involved in the intervention process." No child's life has ever been

threatened under my care. I accept the touchstone that underlies all of ATTACH's safety principle, which is "**to do no harm.**" I accept all of ATTACH's principles for safety and agree that "everyone involved in the intervention process with a child and family is expected to use good clinical judgment coupled with common sense."

My best insurance in reducing safety risk is to make sure I don't operate in an isolated manner and that I am never too arrogant about what I do. I'm open with all significant others, professionals, foster or group home parents, and agencies—anyone connected with the case—regarding my approach, the risks involved, and why a particular intervention is being used and what I hope to accomplish. I don't proceed unless all parties are in agreement and releases are signed. I make it a practice to get ongoing supervision for what I do, especially with regard to my attachment cases. At present, **I get monthly or bimonthly supervision from Diane Feinberg, M. Ed, attachment and bonding specialist, related to my attachment therapy cases.**

***Evaluation/outcomes/follow-up:***

Outcomes are measured in terms of the treatment plan. Treatment ends when both the therapist and clients agree that goals have been achieved. This is measured and assessed in clear and concise behavioral terms. I ask clients to fill out satisfaction questionnaires on a periodic basic basis during and after treatment to get an overall sample of client satisfaction in general. It allows for further comments, which are useful and helping me be attuned to the concerns of my clientele. In addition, several of the managed care companies who refer me clients have their own versions of satisfaction surveys and these are used to rate me as a therapist with the managed care.

***Qualifications of staff:***

The only staff person of my agency/private practice is myself, **Louis M. Di Eugenio, LCSW.** However, at times, I do co-therapy with outside therapists, including family intensives with attachment disordered children.

**I have a Masters Degree in Social Work from the University of Denver, Graduate School of Social Work (1979).**

My attachment work related training is as follows:

1) From 1981 to 1982, while I was on the Family Treatment Team at Jefferson Country Social Services in Lakewood, CO, Ray Curtis from Forest Heights Lodge was a consultant to our team. He is the one who initially introduced me to attachment theory, gave us handouts and trainings, and helped us apply those principles to our cases. The focus of the family treatment team was to prevent adolescents from having to be placed out of the home. We worked with high-risk cases in which there were at least two treatment failures prior to coming to us. 75% of our time was spent keeping kids out of out-of-home placements, 25% was in getting them home earlier than expected.

When I worked in a residential treatment center for adolescents in California, I began to apply the principles Ray Curtis taught me in that setting. We had many children whose behavior became out of control (sometimes physically aggressive) and who ultimately had to be restrained in order to bring them back into control. While I was down on the floor with them, holding them with other team members, I took them through the attachment cycle. This allowed me to see how the attachment cycle worked first hand and I have used attachment theory ever since to help me understand the children I work with. However, in my present work, restraint is always avoided and I'm pleased not to be working in that type of setting anymore.

I have been in private practice since 1991 and all of my treatment for attachment has been provided in that setting.

In terms of **formalized course work**, I will start with the most recent and work back.

- 1) **Reactive Attachment Disorder**—Eric Guy, MSW, LSW, Roanoke, VA 2-18-2008.
- 2) **Attachment Therapy with Adult Clients-Developing Healthy Emotional Intimacy**—presented by F. Lein, LCSW & M. Meinecke, LCSW, 19<sup>th</sup> Annual ATTACH Conference, Providence, Rhode Island, 10-12-07.
- 3) **Narrative, Nurture, and EMDR**—Dr. Joan Lovett, ATTACH Conf. Providence, RI. 10-12-07,

- 4) **Dyadic Developmental Psychology as Applied to Five Experienced Therapists**—D. Hughes, Ph.D. et. Al, ATTACH Conf. Providence, RI 10-11-07
- 5) **Trauma, Attachment and the Body**—Dr. Bessel van der Kolk, ATTACH Conf. Providence, RI 10-10-07
- 6) **EMDR Part II**—Andrew Leeds, Ph.D., EMDR Institute, Inc., Charlotte, NC, Sept. 29-Oct. 1, 2006
- 7) **EMDR Part I**—Steve Silver, Ph.D., EMDR Institute, Inc., Charlotte, March 24-26, 2006.
- 8) **Autism Awareness**—Curtis Bass, Sand Hills, LME, Sandford, NC 9-21-06
- 9) **"Parenting The Hurt Child"**—presented by Gregory Keck, Henderson Co. Library in Hendersonville, NC on May 20, 2005
- 10) **"Pathways to Healing: The Role of Attachment in Families"**—presented by numerous leaders in the Attachment field at the ATTACH Conference in Richmond, VA, on Oct. 3-6, 2004
- 11) **"Rebuilding the Broken Bond"** presented by Nancy Thomas and **"The Neurology of RAD"** presented by Dr. James Lee, at the Covenant Presbyterian Church in Charlotte, NC on March 19 & 20, 2004
- 12) **"Reactive Attachment Disorder: Assessment and Diagnosis in the Treatment Planning Process"**—presented by Bill Goble, Ph.D. & sponsored by WNC ATTACH in Asheboro, NC on Nov. 10, 2003
- 13) **"Attachment Therapy: Current Trends in the Diagnosis and Treatment of children with Trauma-Attachment Problems,"** presented by Arthur Becker-Weidman, Ph.D., at Holiday Inn, Research Triangle Park, February 7, 2003.
- 14) **"Parenting Children with Trauma-Attachment Problems,"** presented by Arthur Becker-Weidman, Ph.D., at Holiday Inn, Research Triangle Park, February 8, 2003.
- 15) **"Understanding and Treating Reactive Attachment Disorder (RAD),"** presented by Kenneth Miller, ACSW, CISW, at the Holiday Inn Brownstone Hotel, Raleigh, NC, Nov. 12, 2002.
- 16) **"20-hr. study group on attachment"** with Jaclyn Claes, Ph.D., full professor at UNCG School of Social Work and Chair of the NC Social Work Certification and Licensure Board, from Fall 2001 to Fall 2002.
- 17) **"Understanding The Complexity of Attachment & Bonding Therapy,"** sponsored by the NC Attachment consortium and North Carolina ATTACH, 4-day workshop with Daniel A. Hughes at the Drury Inn, Greensboro, North Carolina, November 28, 2002 to December 1, 2001.

**18) 13th Annual International Conference on Attachment and Bonding** in Greenville, SC, October 3-6, 2001.

**19) "Attachment Disturbed Youth: A Developmental Approach To Understanding Emotional and Behavioral Difficulties,"** presented by Jim Fitzgerald, Director of Operations, Intermountain Children's Home in Helena, Montana, all day workshop, sponsored by the Children's Home Society of North Carolina, Greensboro, NC, September 25, 2000.

**20) "Treatment For Children Who Cannot Love,"** by Diane Feinberg M., Ed., Psychotherapist and Attachment & Bonding Specialist, all day workshop, Thursday, Sept. 21, 2000 at the Courtyard Marriott Hotel in Winston-Salem, NC.

**21) "Troubled Transplants,"** presented by Richard J. Delaney, Ph.D., sponsored by the Children's Home Society of North Carolina, Greensboro, NC, all day workshop, April 6, 1995.

**22) "Clinical Issues and Adoption,"** presented by Francie Rieser, MA, and sponsored by The Children's Home Society of NC at Oak Tree Family Enrichment Center, August 1994.

This is by no means an exhaustive list but well represents my training in attachment.

**Supervision hours (specific to attachment):**

- 1) Monthly and bi-monthly supervision by Ray Curtis, Forest Heights Lodge, from 1981 through 1982 (18 mos. total) which included daily peer supervision by the family treatment team, Jefferson Co. Social Services, Lakewood, CO with observation behind the one-way mirror (Greek Chorus Method).
- 2) Weekly peer supervision by the family treatment team, including observation behind the one-way mirror, Oak Tree Family Enrichment Center, April 1991-Sept. 1994.
- 3) I have been receiving ongoing monthly/bimonthly supervision as needed (depending on the size of my attachment caseload) from Diane Feinberg M.,Ed. since April 2001.

***Supervision and Consultation Plan:***

I will continue to seek ongoing supervision from Diane Feinberg M., Ed. for my attachment related cases.

I use the following individuals for consultation and supervision on other therapy related issues:

- 1) Dr. John Edwards, Ph.D. and Dr. Barry Bricklin, Ph.D. for consultation regarding forensic cases.
- 2) Dr. Susan Stewart, Ph.D., for general client related issues.
- 3) Deb Young, CCAS, for substance abuse related issues.

***Awards:***

- 1) Social Worker of The Year, March 1995—presented by Guilford County Programmatic Unit of NASW-NC
- 2) Clinical Social Worker of The Year, March 2003—Presented by the Piedmont District Programmatic Unit of NASW-NC

***Professional Membership:***

- 1) National Association of Social Workers (NASW)
- 2) Registered Clinician, Member of ATTACH