

Treatment Protocol for Attachment Treatment
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Philosophy

I am a therapist in a solo private practice in Topeka, Kansas. I work with children who have suffered disruptions in significant attachment relationships. The disruption is often related to maltreatment in the form of abuse and neglect, but may also result from other causes (e.g. chronic pain in infancy, temporary separation from caregiver). When children experience a disruption in attachment, they often have compromised development in many regards. Most have what is called “Complex PTSD”, and suffer in the following ways:

- Problems regulating emotion and arousal
- Alterations in conscious and memory
- Damage to self concept and identity
- Cognitive deficits
- Hyperactivity and attention problems
- Relationship problems
- Alterations in systems of belief

Children who have suffered relational trauma often have a very difficult time feeling safe and trusting of adults. In order to heal, it is critical that children live in families where a corrective emotional experience can be offered. I work to help caregivers create a home environment conducive to healing by teaching therapeutic parenting skills. I encourage families to have high levels of structure, nurturing, engagement, and challenge interactions with the child (based on the Theraplay model). I help caregivers to create an attitude of playfulness, love, acceptance, curiosity, and empathy to help children reduce shame (based on the Dyadic Developmental Psychotherapy model). I teach them how to attune to their child and to manage difficult behaviors. At times, parents have barriers to providing therapeutic parenting. In these cases, I utilize individual or couples therapy to help caregivers resolve issues that are being triggered by interactions with their child.

I am committed to providing effective treatments that aim to resolve the underlying problems and thus the symptoms related to their trauma. The work of researchers, such as Dr. Bruce Perry, Dr. Alan Schore, and Dr. Daniel Siegel has shown the inter-relationship between brain functioning and attachment relationships. The therapy approaches I use are consistent with what these experts have determined to be effective in treating children with attachment problems. My primary treatment model is Dyadic Developmental Psychotherapy, developed by Dr. Dan Hughes.

Description of Processes

Intake/Admissions

When I have a new child to treat, I begin my work with the parents. During the initial sessions, I gather information about the child's history and current symptoms. I also learn about the parent's capacity to provide therapeutic parenting. Further, I explain the methods that I use to help the child and family recover from the child's trauma and strengthen attachment. If the child is in the state's custody, I have the social worker accompany the foster parents so that she/he can be aware of the approaches we will use to treat the child.

If a family is agreeable to the methods of treatment that I use, then we begin to work together. If the family is not open to my approach, I refer them to other individuals in the community. If a family needs more intensive treatment, I help them locate a treatment facility that would be able to meet the intensity of the child's needs.

Assessment

Parents complete the following forms:

- Child Intake form: this document gleans information about many domains of the child's life, such as who lives in the family's home and various aspects of the child's developmental history.
- Sensory Processing Screener: Most of the children I treat have sensory processing deficits. This assessment form is designed to identify children who may need referrals to an occupational therapist.
- FASD Assessment form: This screener was designed by Diana Malbin, expert in problems related to in utero drug exposure. The document helps to identify deficits that are likely related to drug exposure.
- An attachment symptom checklist: this form lists the varied symptoms of attachment disturbance and allows the caregiver to identify the severity of the symptoms.
- Parenting Profile for Attachment Parenting Questionnaire: Dan Hughes developed this tool as a way to identify parent strengths in caring for their child as well as areas of needed intervention. Parent responses to this form help to guide my work with parents.
- Dan Siegel's Questions for Parental Self-Reflection from "Parenting from the Inside Out.": These questions are completed by parents who need further intervention and exploration of parent triggers.
- Marshack Interaction Method: This assessment involves parents and children engaging in a number of parent/child activities that allows me to evaluate the strengths and limitations of responses around 4 domains: challenge, engagement, nurturing, and structure.

I gather all of the documents available on previous treatment, evaluations, hospitalizations, social services reports, social history, etc. These documents are helpful in putting the child's story together. Helping a child to develop a coherent narrative is a critical component to the healing process. If there is limited data on the child's functioning ability, and I feel that it is necessary to obtain more information

on the child, I would refer the family for psychological testing, education testing, and/or a neurological evaluation.

In addition to the assessments listed above, my assessment process includes an evaluation of the child's current motivation to heal. I assess whether they can talk about their life directly. If it's too painful for them, I use methods such as puppets, psychodrama, sand tray, and storytelling to help the child make sense of his/her life, until a child feels safe enough to explore his life in more depth verbally.

Treatment Planning

Information gleaned from the assessment process will drive the treatment process. If parents are not prepared to parent therapeutically, then I work with them to look at unresolved issues that impact parenting. I teach them skills to parent their challenging child. When they have identified and addressed their triggers and can create a home environment rich in PLACE (playfulness, loving, accepting, curiosity, and empathy), then the child joins the therapy process.

I want to have the client and caregivers involved in the planning of the treatment process. Ultimately, however, I have clear methods for how I work and what I feel we need to accomplish. It is important that families are willing to work within the framework that I provide.

The goals of treatment are typically:

- Strengthening attachment and relationships;
- Developing improved living skills; and
- Processing unresolved trauma and grief.

Treatment Techniques Used

My treatment approach is based primarily on the followings models of treatment:

1. **Dyadic Developmental Psychotherapy (DDP):** DDP is a family centered treatment approach to strengthen attachment and resolve trauma. At its core is the use of a safe setting where a child can begin to explore, resolve, and integrate a wide range of memories, emotions, current experiences that are frightening, shameful, avoided or denied. The therapist and parents/caregiver work to provide attunement to the child and maintain an attitude of PLACE (playfulness, loving, acceptance, curiosity, and empathy).
2. **Theraplay Activities:** Theraplay activities aim to replicate healthy parent-child attachment relationships and use four dimensions to do so. Each session includes structure, engagement, nurture, and challenge activities. Theraplay activities help the child to replace inappropriate coping behaviors with healthy, creative, age appropriate solutions by offering activities which aid in self-control and self-regulation. Theraplay activities also aim to increase the child's self esteem by emphasizing the child's strengths and positive attributes. Finally, Theraplay activities

increases the positive interactions between the child and caregiver through emotionally attuned, interactive, physical play; thus enhancing the relationship.

3. **Narrative Attachment Family Therapy:** Children develop beliefs about themselves and the world based on their early experiences with caregivers. Children with negative experiences form negative beliefs, such as "I'm bad", "I don't deserve love", and "I can't be safe". This belief system drives their feelings about themselves and their behavior. Children who think they are bad, act bad. This treatment approach attacks the mistaken beliefs (also called internal working model). Parents intuitively know their child's deepest needs and emotions. With this approach, they create a story, with a protagonist or hero with whom the child can best identify. Through the process of telling the child the story that identifies the child's key struggles, parent's empathy provides a pathway of attunement to their child. This is a critical factor in strengthening attachment.
4. **EMDR:** Eye Movement, Desensitization and Reprocessing, or EMDR, is a powerful approach, highly effective at helping people to resolve trauma, anxiety, disturbing memories, fears, and other emotional problems. The work is based on "adaptive information processing" whereby, "stuck" traumatic or negative memories are linked up with positive beliefs. This leads to resolution of the negative images and beliefs to the point where they are no longer troubling to the individual. This approach is used cautiously with severely traumatized children, as mental exposure to the troubling images that haunt a child is necessary, and can be very difficult for the child.
5. **Neurosequential Model:** This model is based on the work of Dr. Bruce Perry. Essentially, I help families identify the time frame in which a child suffered developmental trauma. This gives us information about the area of the brain that is likely underdeveloped. Activities to strengthen brain development in the underdeveloped area then initiated by the family at home.
6. **Filial Family Therapy:** In this approach, parents are taught to provide attunement to their child, by letting the child take the lead in play. Parents provide commentary while the child plays, to show the child they are aware of every move he/she makes. Parents can be invited into play by the child, or can be an active observer. This is a good way to help the child feel important and connected to the parent.
7. **Sandtray:** I use sand tray work to show the child what he/she deserved as a child. Parents and I work together to create scenes about how life should have been for the child, or would have been if the child lived with the adoptive parents from the beginning. We also use sandtray work as a way for the child to show what life was like when they lived with abusive caregivers. This is a way of deepening the child's and parent's understanding of the child's life, as we move toward helping the child develop a coherent narrative.
8. **Puppets:** Parents and I use puppets to role play difficult aspects of the child's life. For example, if a child is having a difficult time taking baths, we will role play the puppet having the same problem, will look at underlying reasons for the difficulty (e.g. birth parents didn't provide good hygiene for the child), and the puppet overcoming the difficulty. Children often join in.
9. **Psychodrama:** Parents and I act out different parts of the child's life while the child watches and gives feedback on accuracy. For example, we may act out a hard time and how birth parents mishandled it. We then act out what the child deserved and how it would have been handled by the adoptive parents.

Safety Plan

In my approach, I am constantly monitoring how a child is feeling and experiencing the therapy. I work to keep a child regulated and calm. When I sense that a child is having a hard time, I check in with him

about how the work is affecting him. I take breaks in the intensity of the therapy just before a child becomes dysregulated (whenever possible) and engage the child and family in a playful activity to help the child relax, have fun, and feel connected to his parents and to me.

I abide by the safety principles of ATTACH:

- ATTACH opposes coercion in treatment.
- ATTACH opposes abuse in any form at any time.
- ATTACH opposes any intervention or activity that endangers a person's physical or emotional well being or that purposely and intentionally seeks to increase a client's dysregulation.
- ATTACH believes all therapeutic interventions and treatment should be conducted in a respectful manner.
- ATTACH believes that all attachment-based treatment should be based on sound theory, research, and principles, and that therapists should practice within their competence and training and with appropriate supervision/consultation.

I give the message throughout the therapy process that there are "no hurts". When children have a tendency towards aggression, I make sure that parents are trained to properly restrain the child so that the child can feel contained.

I work in a building with many other professionals. I almost always work when there are others in the building. I almost never work with children without the presence of their parent(s). If a child leaves my office, he has a long hallway to pass through before getting outside, which gives the adults ample time to catch up. I keep my cell phone handy in the event that I would need to contact 911 for assistance.

Evaluation /Outcomes/follow-up

When I am treating a child, I know that progress is being made when the following occurs:

- The child increasingly looks to the parent for comfort
- The child's rages reduce in intensity and frequency
- The child can make a repair after a mistake
- Evidence of shame reduces, such as hiding, sneaking, lying, lack of eye contact
- The child can talk about the events in his life, make sense of it, and express feelings about it

To gain feedback on the client's progress, I may repeat assessment measures during the course of therapy, such as the MIM or the attachment symptom checklist.

Therapy gradually moves from weekly (or sometimes twice weekly) appointments, to bi-weekly, monthly, and then termination. In most cases, families stay in touch and come back as needed.