

TREATMENT PROTOCOL

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Statement of Problem and Philosophy:

Most children I treat have experienced early childhood neglect, trauma, and a history of multiple placements. Most have been treated by multiple therapists and some have had multiple hospitalizations. The families that seek an evaluation display little evidence in positive changes throughout previous treatment modalities. The children coming to my clinic often carry a diagnosis of attachment-related issues, posttraumatic stress disorder, bipolar disorder, anxiety disorders, sensory integration disorders, fetal alcohol related-disorders, and other conditions. I work with children under the age of one through adulthood. However, the majority of my clients are 3-12 years of age.

My primary treatment approach is Family Attachment Therapy. I am also currently training with Dr. Arthur Becker-Weidman in Dyadic Developmental Psychotherapy, which is empirically based.

Therapy for children with Reactive Attachment Disorder has three components. The first is designed to help parents understand children with attachment disorder: how they feel, how they think, and their internal psychological dynamics. The teaching of attuned and responsive parenting skills comprises the second part. These skills are designed to help the parents engage the child emotionally in a growth enhancing relationship.

I use the model of creating a healing PLACE. PLACE stands for being playful, loving, accepting, curious, and empathic. The third component involves intensive emotional work with the child and family. This part constitutes a significant portion of the treatment. The basic purpose of treatment is to help the family resolve a dysfunctional attachment and develop a healthy attachment. The goal is to help the child connect to the parents and to come to grips with the disappointment, sadness, fear, and anger at the first attachment figure(s) and their failure to parent. Said another way, the goal is to resolve the fear of loving and being loved. The parent's own families of origin issues are also a focus of treatment as these may create difficulties in the current relationship with their child.

In the Intensive Program, I work for ten consecutive days (two weeks), three hours per day. The intensive therapy takes place at the Lake City Counseling, which is a licensed outpatient counseling agency. Families stay at local hotels or with friends or family nearby. The time in therapy is divided between working with the parents, with the child/adolescent, and sometimes with other members of the family.

In the regular outpatient program, families are usually seen for a two-hour session weekly. Treatment always involves a child and the parents. Sometimes siblings are involved as child has often abused them and corrective work is needed for these relationships. The parents are involved in all treatment. They are either in the therapy room directly or are watching the therapist work with the child from an observation room.

Description of processes:

Intake/Admission:

Admission occurs when a family contacts the agency for services and arranges for an appointment. Before the family's first appointment, a packet of information is sent to them indicating the types of services that I provide. The intake packet includes a welcome statement from the clinic, an explanation of the evaluation process, child registration form, attachment disorder checklist, behavior symptom checklist, sensory integration checklist, , informed consent, financial responsibility agreement with the list of fees, and our privacy policies.

Assessment

Infants and Toddlers: The informed consent document and other releases are reviewed and signed at the initial session. The initial session involves meeting with the parents. The second takes place with the child and parents. The third meeting is with the parents. Assessments for infant and toddlers is accomplished by using the Ainsworth Strange Situation Protocol, Vineland Scales of Adaptable Behavior, an attachment disorder checklist, behavior symptom checklist, and sensory integration checklist.

Children ages 4 to 21: Assessment of children ages four to twenty-one years of age usually involves three sessions. The informed consent document and other releases are reviewed and signed at the initial session. The first meeting is with the parents, the second takes place with the child, and a third meeting with the parents. Typical instruments used include the Child Behavior Checklist (parent, youth, and teacher forms), Attachment Story Completion Test, House-Tree-Person projective test , Vineland Adaptive Behavior Scales-II, Behavior Rating Inventory of Executive Function (parent and teacher versions), psychosocial history questionnaire, sensory-integration screening instrument, Behavior Problems checklist. Other tests and instruments that may be used include: Million Adolescent Personality Inventory, Adult Attachment Interview, Separation Anxiety Test, among other tests and interview protocols.

Assessment of Older Teens: The informed consent document and other releases are reviewed and signed at the initial session. Assessment of older teens often involves an attachment therapy session to assess degree of accessibility and capacity for emotional engagement.

Assessment of Adults: Assessment of adults often involves two sessions. The first session a meeting with the client and/or client and partner takes place. The informed consent document and other releases are reviewed and signed during the session. The session reviews reasons for seeking therapy and other psychosocial history. The second session the Adult Attachment Interview, Vineland Adaptable Scales, Minnesota Multiphasic Personality Inventory, and other tests and protocols as deemed necessary. The psychosocial history is also reviewed during the session.

Each assessment will review of all records such as protective service investigative reports, social histories, adoption summaries, police reports, previous psychiatric, psychological, and social, work evaluations, medical records, school records, treatment records, etc.

The last meeting of the assessment involves a treatment planning session in which the results of the assessment are shared and agreement is reached on treatment and recommendations for additional services is discussed. Clients are referred for additional services if, during the assessment process, clients display needs for services that are not available at Lake City Counseling. Such services are but not limited to occupational therapy, screening for auditory processing, referral for a neuropsychological exam, and referral for an evaluation for possible medication.

Treatment Planning

Treatment planning is based on the outcomes of the tests and measurements used during the assessment. During the third session, the family and/or client is given the assessment. The assessment is discussed with the client along with ideas for possible goals for treatment. The client/family is asked to review possible goals and identify which goals or which additional goals need to be added. Goals will be reviewed every three months or more often if the goals have been met for treatment.

Contracting is used during the assessment phase. It is also during the assessment that clients are asked to identify issues that bring them to counseling which helps guide the treatment planning process.

Treatment techniques used:

The treatment techniques used are but not limited to:

- Contracting with the child and parents.
- Treatment Planning and modification.
- Education of the child and parents.
- Processing the child and family's trauma.
- Processing and working through the grief and loss experienced by the child and family.
- Cognitive restructuring of the child and parents to challenge and re-pattern thought processes that interfere with healthy reciprocal relationships.
- Therapeutic cradling of the child by the parents and/or therapist(s) focusing on nurturance and the attunement process.

This is an across the lap nurturing cradling, as one would hold an infant. I do not use wraps, compression holds, or holds that utilize provocative stimulation, i.e. screaming and/or painful stimuli. Therapeutic cradling is not the same as restraint. Restraints may be used only if the child is exhibiting imminent risk to harm self or others. Restraint techniques are solely for the purpose of maintaining the immediate safety of the child and others and do not resemble therapeutic cradling and is not a part of therapy.

- Interpretation "color commentary" of the child's life and decisions focusing on describing and expressing feelings while expanding the range of feeling that the child can recognize and utilize.
- Validation of the child's feelings while broadening the emotional options available to the child.
- Psychodrama, psychodramatic reenactment, and role-playing of prior significant events and trauma.
- Training the child and family to utilize empathy, nurturing, and reciprocity.
- Teaching the parents how to create a healing PLACE by being Playful, Loving, Accepting, Curious, and Empathic.
- Helping parents understand and address the parents' own family of origin issues and attachment history in order to become more effective parents.
- Strategic interventions utilizing paradoxical prescriptions.
- Modeling behaviors, expression of feelings and alternatives.
- Reparation for hurt and wrongs done in the past and present.
- Eye contact.
- Interrupting the child's behaviors.
- Talk for the child.
- Talking about the child.
- Consequences for child's behaviors (natural & logical).
- Elements of therapeutic parenting as described in *Building the Bonds of Attachment* and *Facilitating Developmental Attachment* by Daniel Hughes, PhD; *Attaching in Adoption* by Deborah Gray; and *Parenting from the Inside Out* by Dan Siegel, and *Parenting with Stories* by Joanne May. Not all elements in these texts are used.

- Eye Movement Desensitization and Reprocessing
- Written assignments

Safety/risk management plan:

Parents are involved in all sessions. The parents are either in the room with the child or watching on closed circuit TV. All sessions are videotaped. Two therapists are sometimes involved in treatment. Close attention is paid to the child's emotional state to avoid the need for restraint. Staff are trained in appropriate procedures in the event that the child becomes a danger to self, other, or property. The staff adheres to the ATTACH White Paper on Coercion, which provides guidance and suggestions on avoiding and preventing the dysregulation of clients in treatment.

Evaluation/outcomes/follow-up:

At the conclusion of treatment, outcome measurements are taken. The Vineland Adaptable Behavior Scale and Child Behavior Checklist is resubmitted. The parents are also asked to write a summary of their experience in therapy. The family is provided a summary of treatment upon termination of services. Included in the summary are recommendations and the findings from the Vineland.

One year after therapy has concluded, the Vineland Adaptable Behavior Scales and Child Behavior Checklists are resubmitted to the family as well as the last goal plan. The family is asked to review the last goal plan and indicate the progress on their goals and any new goals they may identify.

Qualifications:

I have been working with children, adolescents, and their families for nine years. I originally received training in Strategic Family Therapy and worked as a mental health counselor in a child and adolescent psychiatric facility. The growing psychiatric issues in very young children appeared to be increasing at an alarming rate. I decided I wanted to help such families so they would not feel so limited and unable to help their child. I then started working as crisis worker conducting in-home therapy. My job was to help the family maintain placement and function more effectively. I was presented with an opportunity to learn to work with children with attachment issues and jumped at the offer. I trained with Arleta James in 2005. I also completed level 1 training in EMDR that same year. I currently receive bi-weekly consultation from others in my practice and monthly consultation from other therapists trained in attachment theory and EMDR. I also receive consultation from Dr. Arthur Becker-Weidman on difficult cases. I have also started training with him in Dyadic Developmental Psychotherapy.

Clarifications for Treatment Techniques:

EMDR: I am trained in Level I EMDR. I do not have the Level II training. I use EMDR when children are farther along in therapy and they need work regarding specific traumatic issues.

Theraplay: I do not have certification or training in Theraplay, however I have learned some Theraplay techniques from Arleta James and through reading. I will use such techniques and often recommend the parents either attend a training or read information to learn ways to playfully engage with their child.

Holding: Most of the “holding” used in therapy is with young children. Often this is a natural response. Children often come into the room and sit on their parents lap. When the child does not naturally sit on the parents lap but displays a desire for closeness, this therapist suggests the child “cuddle with mom” on her lap. If the child is not interested in the closeness, the child is not coerced. Sitting on the lap and being “held” by the parent is always voluntary.

“Holding” is described as a child being cradled by his parent. When cradling, the focus is on attunement and nurturing. Cradling is when a child sits across his parents lap much like when a parent holds an infant. When a child is being cradled, he is not being restrained. Being cradled is something the parent and child enjoy. However, if the child becomes dysregulated or wants to no longer be cradled, he is able to immediately move to a more comfortable position in the room. Therapist holding is rarely used as parents are most often in the session. Since cradling is most often used with younger children, the parents are always in the session and would thus provide the nurturing support for their child. Therapist holding is used when the child needs and desires to be held but the parent is too angry to provide emotional safety and security for the child.

Restraint: Restraint is not a part of my standard practices. However, at times a child may be in imminent danger because he attempts to harm himself or others. The least restrictive measures are first taken when a child displays dysregulation such as helping the child to regulate using such options as a swing, weighted items, or compressions by the parents. If he is unable to be regulated and escalates to a point where he is attempting to harm himself or others, the child is then restrained by his parents. I will help the parents restrain the child if requested by the parents. Restraints are solely used for maintaining immediate safety for the child and others. Restraint is stopped when the child is regulated as evidenced by affect and behavior. It must be noted that all efforts to maintain regulation are used before restraint is used. Thus restraint is rarely used.