

TREATMENT PROTOCOL
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Philosophy:

The focus of my attachment practice currently is based on specialized training in Dyadic Developmental Psychotherapy (DDP) (Daniel Hughes).

“DDP”, in my practice, refers to treating children whose attachment experience with primary caregivers in the first five years of their lives was disturbed, and that disturbance has led to emotional and behavioral difficulties in their present lives. I provide conjoint therapy with the caregiver/s and child together. I appreciate Daniel Hughes’ concept of the therapist as a ‘midwife’ for the ‘birth’ of a increasingly full relationship between the child and caregiver/s. My practice is informed by neuroscience research (Bruce Perry, Daniel Siegel, Besel Van der Kolk) which explains the biological processes that underlie the difficult behaviors of these wounded children. I am currently honing the integration of play and expressive arts techniques with those used in DDP.

Description of processes:

Intake/ Admission:

My intake consists of phone contact with the caregiver to discuss the caregivers overall treatment goals and the appropriateness of my practice for meeting those goals. We then set up an initial meeting for the caregivers to come without the child to begin the assessment process. In this initial meeting, I review the overall goals for treatment, length and frequency of sessions, the cancellation policy, assessment period, confidentiality, the impact of issues of culture (e.g. ethnicity, gender, age, religious affiliations, etc.), realistic expectations for children’s behavior during therapy, patient rights and termination procedures. We complete formal consent agreements for: treatment, privacy practices, audio-visual recording of sessions (as appropriate), payment, cancellation policy, and authorizations to release information (as appropriate).

Assessment:

In that first session, and in as many succeeding sessions as needed, I complete two intake interview protocols with the caregiver/s.

The first is my Child Assessment and History, and is focused on the child and the child’s family, and includes the following components: Medical History; Current

Medical treatment; Mental Health History; Current Mental Health Treatment; Life Stages History – Pregnancy, Early Development, Childhood, Adolescence; Educational History; Spiritual History; Legal History; Symptoms of Concern, including somatic presentation, affective experience, risk factors and red flags, social supports, family relations, traumatic stress symptoms; Mental Status Observations; Alcohol and Other Drugs Screen; Domestic Violence Screen.

The second is a Parenting Assessment and History, focused on the caregiver (this is based on materials from Daniel Hughes, PhD and Daniel Siegel, MD). This includes: Parent experiences with the child: Challenges, Frustrations, Resentments. Parental History: Early plans for parenting, Effects of their own parents on their plans for parenting; Hopes and Dreams for child at various developmental stages; Present status of Hopes and Dreams. Then I use Daniel Siegel's "Questions for Parental Self-Reflection" (Parenting from the Inside Out, Tarcher Putnam, 2003, p. 133).

When I determine that it is appropriate, I may meet with the child once individually, without the caregiver present. I may use the Child Depression Inventory (1982, Maria Kovacs, PhD. Multi-Health Systems, Inc), and/or the Trauma Symptom Checklist (1989, Psychological Assessment Resources, Inc.).

The completion of the assessment procedure includes a 5 axis DSM diagnosis and treatment plan, often structured in a paperwork format that is requested by the client's insurer or case manager.

Treatment planning:

This begins in the intake session and is solidified with the caregivers prior to the entry of the child. I will facilitate the child owning the treatment plan for themselves, in a manner consistent with the developmental age of the child and the dynamics in the relationship between the child and the caregiver. This may involve writing a list of goals on a white board or large paper, or may be a simple conversation or a role play with puppets.

The caregiver has the authority to approve or request changes to my treatment recommendations, and the treatment plan is a collaboration between the caregivers and myself. The child should feel ownership of some version of this plan, according to their ability.

Treatment techniques used: see checklist below.

Safety/risk management plan: .

I have listed the ATTACH guidelines, as I believe they reflect my treatment approach. Below I will include some specifics of how I incorporate these into my practice.

- *All participants involved in an intervention will ensure that the physical and emotional health and welfare of everyone involved in an intervention are monitored.*
- *Each person will be responsible for seeing that effective steps are taken to adjust or terminate an intervention process when there is any indication that someone's psychological or physical safety may be being compromised.*
- *The child will never be restrained or have pressure put on them in such a manner that would interfere with their basic life functions such as breathing, circulation, temperature, etc.*
- *Parents and/or other appropriate individuals should observe, participate in, and/or monitor the therapy process being utilized.*
- *Touch is always and only used for therapeutic purposes.*
- *Therapeutic interventions will be carefully selected to as to protect the child from physical pain.*
- *No form of shaming, demeaning, or degrading interaction is acceptable as a therapeutic intervention.*
- *Treatment options, such as holding, paradoxical interventions, and "time outs," should never be used as punishment for perceived misbehavior.*

I also agree that the following questions are ones that inform my treatment.

- *What am I trying to accomplish with this particular child and/or family?*
- *Will this intervention contribute to what I am trying to accomplish?*
- *Is there a less intrusive or less restrictive intervention that will accomplish the same purpose?*
- *What, if any, safety issues should I consider when selecting an intervention for a child and their family?*
- *What are the treatment implications when deciding not to use a specific intervention with a particular child and family?*
- *How do I provide effective treatment interventions while at the same time maximizing the well-being and safety for everyone involved in the intervention process?*
- *Is everyone involved in the intervention informed and appropriately prepared to carry out his or her part of the process?*
- *Is the intervention being considered within the standards of practice, and ethical standards of the California Board of Behavioral Sciences, as well as the NASW, and my own personal ethical standards?*

Some characteristics of my practice which I believe contribute to the achievement of the above safety/risk management plan are:

- My attachment work is nearly always conjoint, with caregivers present in the session.

- I am seated between the child and the door, so as to protect the child from leaving the office suddenly.
- I am always within a couple of feet from the child so I can intervene to protect her/him at any time as needed.
- The phone is within my reach, not the child's.
- I explain to the caregivers and child, in age appropriate ways, their rights as patients, and their power in the process.
- I participate in weekly individual peer consultation to discuss cases – e.g. course of treatment, goals, interventions and transference/countertransference.
- I participate in weekly group consultation to the same end.
- I receive individual consultation from a local consultant experienced in the field, once to twice a month.
- I complete at least 20 continuing education units per year, and stay abreast of dialogue in the ATTACH professional community.

Evaluation /outcomes/ follow-up:

I evaluate the progress of my clients by continually assessing the following data:

- Caregiver report,
- Child's report
- Child's presentation (affect, voice, speech, behavior, hygiene, reality testing, i.e. Mental Status)
- Caregiver's presentation (as above)
- Child and Caregivers interactions in my office
- Child's work (art, written),
- Other involved parties' reports (other providers, school personnel, etc.)

I track the outcomes of my cases through professional consultation about the progress of my cases as assessed above.

My follow up procedures are grounded in my treatment protocol – from the beginning of treatment, the caregiver, child and I have discussed the context of treatment in terms of the issues that brought them to seek treatment, the means by which we are going to address those issues, and how we will begin the termination process when the caregiver, in consultation with me, decides that we have sufficiently addressed the treatment issues. Follow up, after termination, is available to the family in whatever way best meets their needs. For example, they may choose to have me contact them after termination, perhaps a month, or several months later, to see how they are doing. They may choose to have a check-in session, or sessions, periodically after termination. Or they may choose to initiate contact with me as a follow up, instead of vice versa.