

Craig W. Clark, MA, MFT

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Safe Practice Protocols

Principles of treatment:

- Eye contact, tone of voice, touch, movement, are employed to communicate safety, acceptance, playfulness, curiosity, empathy and love.
- Successful reciprocal interactions are desired.
- Opportunities for joy, laughter and fun are actively sought and fully celebrated during the course of therapy.
- We accept the child's symptoms as expressions of his/her history, without shame.
- The child's resistance to treatment is accepted without shame, and the accompanying affect is co-regulated by the parent/caregiver and therapist.
- The adult's affective self-regulation serves as a corrective model for the child.
- Empathy is expressed for the child's experience, affective expressions and behaviors. Exploring these aspects of the child's life will lead to a cognitive understanding of the child's underlying motivations, but is not considered as an excuse for poor behavior.
- We hold the belief that the child is doing the best he/she can, considering the circumstances of their history and developmental (as compared to chronological) age.
- There are no "hurts" either physical or through disrespectful language. We constantly strive to honor the dignity of each individual.
- Children are not threatened or intimidated as part of therapy.
- Occasionally an adult, for the purpose of containment when the child is dysregulated and in an out-of-control state, may cradle a child. The primary concern is for the child's safety and welfare and the safety and welfare of those in close proximity. The goal is to help the child regain control over the expression of their emotions in much the same manner as one would sooth a frightened youngster. It is not to threaten, intimidate or otherwise coerce a child.

Other methods employed to enhance communication between the therapist and clients, and to promote achievement of therapeutic goals:

- Treatment planning and periodic evaluation with modification if called for.
- Psycho-educational referrals to books, educational video, etc.
- Referral to local parent support groups.

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- Review of videotape of previous sessions.

The following are interventions that I **do not use** in treatment: (quoted from “Creating Capacity for Attachment”, 2005)

- Holding a child in anger, or other types of confrontation techniques.
- Holding a child to provoke an emotional response.
- Holding a child until the child complies with a demand.
- Shaming a child or eliciting fear to get compliance.
- Poking or provoking a child to engage in long or painful physical activities in order to get compliance or a response.
- Tightly wrapping a child, lying on top of a child, “rebirthing”, or similar techniques.
- Interventions based on power/control and submission.
- “Firing” a child from treatment because of non-compliance.
- Blaming the child for one’s own rage.
- Labeling the child’s behaviors or symptoms as meaning that the child does not want to be part of the family and then making the child “suffer” the consequences, by:
 - Sending the child away to live elsewhere until he complies.
 - Putting the child in a tent outside until he/she complies.
 - Having the child eat in the basement until he complies.
 - Making the child stay in her room until he/she complies.
 - Making the child sit motionless until he complies.

Treatment evaluation/outcomes/follow-up:

- As a further safeguard and to help ensure that my clients receive the most efficacious treatment, I regularly submit videotapes of my sessions (with prior client consent) to respected colleagues and/or organizations, which have extensive experience in the field of attachment-based therapies. These videotapes reviewed for the purpose of providing analysis of case progress, supervision for certifications, and advanced continuing education.
- After treatment is terminated, I regularly contact my clients to check-in with them about the current status and welfare of their children and families. I encourage my clients to give me regular feedback about how they view the therapeutic treatment I provide and to make suggestions as to how to improve my methods, etc.

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ATTACH Registered Clinician Philosophy of treatment

I enjoy working with children, adolescents and their families. In my clinical practice I utilize approaches that are proven effective in treating children and adolescents who may have experienced trauma due to childhood abuse, neglect or abandonment. These children have already experienced harm and I take great care not to cause them to be re-traumatized by the clinical interventions that are designed to help them heal and grow into healthy individuals. I utilize models of treatment that holistically approach the needs of the child to form more secure and reciprocal attachment relationships with his parents or caregivers, and to reduce the negative behaviors and emotional reactivity that many children employ. I use a variety of methods that are integrated to best achieve desired treatment goals while at the same time, respect the individual needs of the family members and the uniqueness of each family experience. The two primary models of treatment are Dyadic Developmental Psychotherapy and Theraplay . Depending on the situation and age of the child, therapy may utilize either of these modalities. Sometimes, I may use them in a coordinated approach.

Dyadic Developmental Psychotherapy is a “gentle, holistic, therapeutic approach designed to resolve trauma in children who have experienced abuse, neglect, loss or other extreme challenges to primary relationships...” (Creating Capacity for Attachment, 2005) The approach utilizes the therapeutic stance described by the acronym, “PACE”, which stands for, *playful, accepting, curious, & empathic*. This is the role utilized by the therapist when working with the child in treatment. The parent is present for most of the sessions, either in the room with the child or sometimes observing the session via closed circuit TV. In this style of therapy, the parent is an integral part of the therapeutic process. The parent/child relationship is the focus of the treatment and it is explored, examined and experienced throughout the treatment sessions. The parent/caregiver is encouraged to utilize the stance represented by the acronym, “PLACE”, which stands for, *playful, loving, accepting, curious, & empathic*. While this is basically a “talk” therapy, we may also employ, psycho drama, art, music or play therapy approaches as long as these approaches promote the progress of the treatment and serve as tools to accomplish the exploration of the client’s inner psychology, the meanings they attribute to their life experiences and relationships in order to form more secure primary attachments with their caregivers/parents.

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Theraplay is another form of treatment I utilize when working with younger clients, ages three through eleven. (Note: these ages are approximate as the child may be developmentally of a younger age than his/her chronological age). Theraplay utilizes interactive play based on early childhood play activity commonly experienced between a parent and their infant through toddler age child. These play-based activities are divided into four domains for the purposes of treatment. They are: *structure, engagement, nurture & challenge*. Structure will serve to “relieve the child of the burden of maintaining control of interactions. The adult sets limits, defines body boundaries, keeps the child safe, and helps to complete sequences of activities.” Engagement helps to “establish and maintain a connection with the child, to focus on the child in an intense way and to surprise and entice the child into enjoying new experiences.” Nurture serves to “reinforce the message that the child is worthy of care and that adults will provide care without the child having to ask.” Challenge helps the child feel more competent and confident by encouraging the child to take a slight risk and to accomplish an activity with adult help.” (The Theraplay Institute, 2003)

These therapeutic approaches are proven to be effective in reducing the behavior symptoms that are often associated with a variety of disorders including: Reactive Attachment Disorder, Posttraumatic Stress Disorder, Oppositional Defiant Disorder, Attention Deficit Disorder, and others. Additionally, this treatment approach addresses the underlying fears, misperceptions and distress from which this population of children may suffer, and which contribute to their disturbing behavior and lack of healthy attachment relationships.