

Center For Family Development

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TREATMENT PROTOCOL

Problem Statement

The Center For Family Development treats children and their families. The program provides treatment for children with trauma and attachment disorders, including Reactive Attachment Disorder, Post Traumatic Stress Disorder, and other related disorders, which may be described as a Complex Trauma¹ or Developmental Trauma Disorders. The Center treats children with histories of abuse and neglect, multiple placements, histories of institutional care, and internationally adopted children. The Center treats many trauma-attachment disordered children who have comorbid conditions such as Post Traumatic Stress Disorder, Bipolar Disorder, Anxiety Disorders, Sensory-Integration Disorders, Alcohol Related Neurological Dysfunction, and other conditions.

Target Population

The target population treated is children from birth to twenty-one years of age and their families. The Center also treats adults with trauma and attachment difficulties. Currently the majority of the Center's clients are children age four years to nineteen years of age.

Program/Practice Overview

Most children we treat have significant histories of chronic early maltreatment within a caregiving relationship. Many have lived in one or more foster homes and have suffered neglect and physical and/or sexual abuse. A high percentage of children treated here are adopted, many from overseas orphanages. Some experienced medical/pain trauma as infants or prolonged or frequent separations from primary attachment figures during the first few years of life. Almost all have had several years of therapy with one or more therapists. Some have been hospitalized one or more times or been placed in Residential Treatment Centers. Whatever the help, there is little evidence of positive change as measured by

¹ Cook, A., Blaustein, M., Spinazolla, J., van der Kolk, B. (2003) Complex trauma in children and adolescents. White paper from the national child traumatic stress network complex trauma task force. Los Angeles, CA: National Center for Child Traumatic Stress.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., et. al. (2005) Complex trauma in children and adolescents. *Psychiatric Annals*, 35:5, 390-398.

**REGISTERED AGENCY: ASSOCIATION FOR TREATMENT AND TRAINING IN THE ATTACHMENT OF CHILDREN,
COALITION OF ADOPTION SERVICES IN ERIE AND NIAGARA COUNTIES,**



improvement in the child's behavior and in his or her ability to trust. The following elements describe the attachment work done at *The Center For Family Development*.

Affective attunement² and the congruent intersubjective sharing of experience are central elements of the effective treatment of children with trauma-attachment disorders. Attunement, addressing affect, and reengagement describe the cycle of treatment that is identical with the normal parent-child interaction seen in infancy and the toddler years. Key to treatment is helping the child develop an integrated sense of self that allows of effective affect regulation; development of a coherent autobiographical narrative, and trusting authentic emotionally engaged relationships. Intersubjectivity refers to shared emotion (attunement), share attention, and share intention.

Our primary treatment approach is Dyadic Developmental Psychotherapy, which is a well-recognized and evidence-based treatment for disorders of attachment³. The proposed treatment approach is consistent with generally recognized treatment protocols for Reactive Attachment Disorder and Complex Trauma.

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. We 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 family of origin issues are also a focus of treatment as these may create difficulties in the current relationship with their child.

² Siegel, Daniel, *The Development Mind*.

³ Becker-Weidman, A., (2006) "Treatment for Children with Trauma-Attachment Disorders: Dyadic Developmental Psychotherapy" by Arthur Becker-Weidman, Ph.D., *Child & Adolescent Social Work Journal* 23-2, 147-171.

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Becker-Weidman, A., & Shell, D., (Eds.) (2005) *Creating Capacity for Attachment*, Wood 'N' Barnes Publishing, OK.

Craven, P., & Lee, R., (2006) *Therapeutic Interventions for Foster Children: A Systematic Research Synthesis*, *Research on Social Work Practice*, 16:3, 287-304.

Hughes, D., (2006). *Building the Bonds of Attachment*, 2nd. Ed., Guilford Press, NY.

Hughes, D., (2008). *Attachment focused family therapy*, Norton, NY.

In the Intensive Program, we work for ten consecutive days (two weeks), three hours per day. This is an outpatient facility. Families stay at local hotels or with friends or family nearby. Two therapists and a Family Specialist are generally used. If indicated, the child may stay in a therapeutic foster family for all or part of the two weeks. The time in therapy is divided between working with the parents, with the child/adolescent, and sometimes with other members of the family. Referring therapists are encouraged to come with the family and be a part of the therapeutic team, if they are available to follow-up with the family after the two-week intensive. The availability of a trained follow-up therapist is required. If a trained therapist is not available, then a therapist can be brought to the intensive to be trained by our staff.

In the regular outpatient program, families are usually seen for a two-hour session weekly.

Treatment always involves a child and the parents. Sometimes we involve siblings as the 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 therapists work with the child from an observation room.

In addition to using standard verbal psychotherapy techniques, we use techniques designed to engage the child in corrective emotional experiences. Their trauma is locked into the experience of having felt pain at a time when they were powerless to get the help they needed. A variety of therapeutic techniques (psychodrama, imagery, art-therapy, social skill-building, and holdings) are used to elicit and correct the child's pathology.

The therapy has a major emotional or affective emphasis. We operate with the philosophy that emotions have a major causative effect on behavior. We believe that when the emotions that cause the behavior change, the behaviors will change, sometimes with little or no discussion. In our experience, the trauma the children have experienced, which often includes the loss of their birth family, neglect, and abuse, produces three major emotions: fear, sadness, and anger. These emotions provide the causal energy for most of the child's difficulty and challenging behavior. All behavior is viewed as adaptive and it is essential to understand what is driving or motivating behavior. Consequently, the regressive work that helps them access their fear, sadness, and anger is a process that helps them heal from their emotional trauma(s).

In essence, all therapy conducted at *The Center For Family Development* is done under three clear contracts.

PARENTING APPROACH:

Many children with disorders of attachment require a *secure, stable, very consistent, warm, and loving home*. The effective parenting of a child with Reactive Attachment Disorder requires attachment parenting,⁴ which is quite different from "normal" parenting or behaviorally based models. Specific elements of parenting that are required are the following:

1. Create a healing environment
 - a. Set a positive tone for the family

⁴Creating Capacity for Attachment edited by Arthur Becker-Weidman, Ph.D., & Deborah Shell, Wood 'N' Barnes Publishing, OK, 2005.

Building the Bonds of Attachment, 2nd. Edition, Daniel Hughes, 2006.

- b. Provide frequent genuine nurturance, attention, and love, verbally and physically.
 - c. Encourage the child to be affectionate. Take the lead in providing consistent and frequent affection.
- 2. Create clear and consistent structure. Structure creates a feeling of safety and security for the child
 - a. Set appropriate rule and realistic limits and consistently enforce.
 - b. Keep an organized home with consistent times for homework, meals, bedtimes.
 - c. Predictable routines develop feelings of safety and security and help an attachment-disordered child learn to experience the caregiver as reliable and trustworthy.
- 3. Communicate effectively.
 - a. Send warm, loving, accepting messages.
 - b. Use eye contact and touch to encourage your child to listen and hear.
 - c. Make positive rather than negative statements.
 - d. Praise and approval must be about specific behaviors and accomplishments.
 - e. Discipline in a calm, neutral manner.
- 4. Use consequences rather than punishments.
- 5. Competency based parenting. Secure attachment develops as a result of the interplay between structure and freedom, and dependence and independence.

The parents must physically structure the home to provide a safe and appropriate environment for the child. The method I use involves helping the family become able to use therapeutic foster care knowledge and skills. The parents must have the ability and psychological capacity to function like a therapeutic foster parent. The parents must provide the proper high and consistent degree of structure and warmth necessary for the child to heal by developing trust and security. This environment allows the child to bond with the parent. As all the parents I work with will attest, this is very demanding work; some parents have described it as the hardest thing they have ever had to do. It requires parents who are able to consistently adhere to a structured and well-regulated program. The expectation is actually significantly higher than that typically found in therapeutic foster homes. It requires parents who are able to effectively manage their anger and frustration and not allow those feelings to interfere with being a warm and loving parent. It requires parents who can put the needs of the child first. My experience is that adults with current serious personality disorders, co-morbid addiction, bipolar disorder, or attachment disorder, among other conditions, do not have the ability to effectively parent an attachment-disordered child.

Initially, it is best for the parent to be with the child, as one would be with an infant or toddler, all day and to keep the child within arm's length. This initial period to "line-of-sight" supervision, coupled with an attitude of empathy, love, curiosity, and playfulness sets the stage for the child to become connected to the parent. This initial period can be as brief as one month, or last as long as several months, depending on the child's level of disorder and ability to begin to trust the parent.

For further details see the Center's program description, informed consent document, and other releases, attached.

Range of Services

1. Evaluation and Assessment. Center staff can conduct a comprehensive evaluation that results in a diagnosis and treatment plan.

2. Treatment of Complex Trauma and children with trauma-attachment disorders. Therapy involves sessions that occur at regular intervals. Sessions are usually two-hours in length. The parents are included in all sessions either in the room or viewing through a one-way mirror or by closed circuit TV.
3. Two-week Intensives. Ten sessions each three hours in length spread over two weeks. Two therapists and a family specialist are involved in treatment. The family specialist provides training in effective parenting methods and visits the family during the two weeks to demonstrate parenting principals and to coach the parents. See attached description of the two-week intensive.

Description of Services

Admission occurs when a family contacts the Center and arranges an appointment.

Assessment: (Details are provided in the book *Creating Capacity for Attachment and in the DVD, Assessment, available on the Center's website*).

1. Assessment of attachment behavior of infants and toddlers is accomplished using the Ainsworth Strange Situation Protocol⁵
2. Assessment of children ages four to twenty-one years of age usually involves three sessions. There is a meeting with the parents, one with the child, and a third meeting with the parents. Typical instruments used include the Child Behavior Check list (parent, youth, and teacher forms), Attachment Story Completion Test, House-Tree-Person projective test, Kinetic Family Drawing 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.
3. Assessment of older teens often involves an attachment therapy session to assess degree of accessibility and capacity for emotional engagement.
4. 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. The informed consent document and other releases are reviewed and signed at that session. See attached for copies of these documents.

Techniques used are described in the informed consent document:

- 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

⁵ Ainsworth, Mary, Blehar, Walters, & Wall, 1978, *Patterns of Attachment*

- 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) may on occasion be used. When used, cradling is focused on nurturance and the attunement process. *This is an across the lap nurturing cradling, as one would hold an infant. At The Center For Family Development we 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 Dyadic Developmental Psychotherapy.*
- 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
- Validate 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 Creating Capacity for Attachment edited by Arthur Becker-Weidman, Ph.D., & Deborah Shell, Building the Bonds of Attachment and Parenting from the Inside Out by Daniel Siegel, M.D. Note that not all elements in these texts are used for supported by The Center For Family Development.
- Eye Movement Desensitization and Reprocessing
- Written assignments

The following are interventions that we **DO NOT USE**:

1. Holding a child in anger and confronting the child.
2. Holding a child to provoke an emotional response.
3. Holding a child until the child complies with a demand.
4. Shaming a child or eliciting fear to get compliance.
5. Poking or provoking a child in order to get a response.
6. Coercing a child to engage in long or painful physical activities in order to get compliance or a response.
7. Wrapping a child, lying on top of a child, “rebirthing,” or similar techniques.
8. Interventions based on power/control and submission.
9. “Firing” a child from treatment because of non-compliance and punishing a child at home for being “fired” from treatment.
10. Sarcasm or laughter at a child about the consequences being given the child.
11. Interventions that are based solely on compliance; “Basic German Sheppard Training.”
12. Blaming the child for one’s own rage.
13. 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:
 - a. Sending the child away to live elsewhere until the child complies
 - b. Putting the child in a tent outside until the child complies.
 - c. Having the child eat in the basement until the child complies.
 - d. Making the child stay in the child’s room until the child complies.
 - e. Making the child sit motionless until the child complies.

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 or through a one-way mirror. 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 restraint 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 for avoiding and preventing the dysregulation of clients in treatment.

Evaluation/outcomes/follow-up

At the conclusion of treatment, parents and child are encouraged to write about their treatment experience. Our website has a number of these postings. The Center has completed two outcome studies that have been published in professional peer-reviewed

publication and which have been cited earlier in this document. In addition, the Center is conducting another series of studies using the Vineland Adaptive Behavior Scales. .

Qualifications of staff

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Certified Therapeutic Foster Parent, Niagara County, NY