

PROTOCOL
Linda M. Ikeda, RN. MFT

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I. Treatment Protocol

Philosophy: The child needs to be attached to an attachment figure in order to heal and this simple sounding task is actually quite complex. Because of areas in the brain that did not sufficiently develop due to trauma in infancy and early childhood, or prenatal trauma such as in utero exposure to drugs/alcohol, the child has not learned to trust, develop a conscience or have a relationship. Attachment is the building block of all future development, so when attachment does not occur, neurological, cognitive, emotional and social functioning is impaired. This has a lifelong impact on the child's functioning in the world and without treatment, the child is at risk for other serious problems.

Attachment can occur between a child and a primary caregiver who does not have to be the birth mother but could be a foster or adoptive parent. When attachment has occurred, the child is able to trust, have empathy for others, "give back", take responsibility for their actions and know the difference between right and wrong.

Every child, being unique, expresses attachment difficulties in various ways. Appropriate attachment therapy and parenting can assuage the effects of breaks in attachment. Growing up in a safe, consistent and nurturing home promotes healthy attachment in children.

Families will bear the bulk of the burden of healing attachment problems in their children and therefore it is crucial to the child's healing, that the parents are seen as a vital part of the treatment team and are present during therapy. In addition to therapy, they may benefit from the support of outside services such as: parent support groups, neuro-feedback, occupational therapy, speech therapy, etc. It is also crucial that the family is committed to the child's healing and placement. My approach tends to be a combination of Daniel Hughes, Holly Van Gulden, Deborah Gray, and Daniel Siegel.

Target Population-I have had a general private practice until nine and one half years ago when I became involved in an orphanage in Romania and

learned about less than optimal attachment in children. Since then I have been on a high learning curve about attachment so that I could educate the orphanage staffs and other Romanian professionals. I have also begun to target 14 orphanages in Nepal, as well as those assisting orphaned and traumatized children in Uganda and Burundi, for similar kind of trainings. Due to a large grant, I have been able to study under Daniel Hughes, Daniel Siegel, Allan Schore, Terry Levy, Michael Orlans, Deborah Gray, Ira Chasnoff, Bruce Perry, and Holly Van Gulden among others.

Currently my practice is about 50% families with attachment challenged children. These are complex cases and most have been adopted into families from the foster care system or foreign orphanages. Each of these children are attachment avoidant and many have the diagnosis of Reactive Attachment Disorder (both inhibited and disinhibited types) and Post Traumatic Stress Disorder, (complex and chronic). These children have been between 18 months and 20..

Level of Practice-

I am a therapist with extensive training and 9 1/2 years of experience, with a specialized attachment practice. I provide therapy using a wide range of tools and techniques from the attachment literature.

Range of Services-

I provide office based Dyadic Developmental Psychotherapy I have helped facilitate a foster/adoptive parent's support group, as well as taught other clinicians about attachment in various settings. I have also provided training and treatment in Romania, Nepal, Uganda, Burundi as well as many parents and therapists in Santa Clara and San Mateo Counties.

Description of Services-

Assessment-

Intake and initial assessment using the RADQ (developed by Dr. Elizabeth Randolph), the symptom checklist developed by Terry Levy, the child Beck depression Inventory, the Beck Depression Inventory for each parent, the child/adolescent DES, the Dan Hughes' two Parent Questionnaires, an infant development assessment, the SASI, a strengths and difficulties questionnaire, a child biography form I developed as well as an extensive genogram. If I were unable to engage a child in therapy, or if a parent was unwilling to participate in the sessions, I would refer them elsewhere.

A thorough social and psychological assessment is done through history taking and by observation. I depend heavily on the history and list of symptomatic behaviors that the parents report. I obtain consents to consult with child's pediatrician, teacher, neuro-psychologist and social worker (where applicable) so that I can benefit from a clearer, multi-setting picture of the child. Because of my nursing background, I am particularly interested in the client's medical history which I keep in mind when planning interventions (e.g., if a child has a history of asthma, I will be watching for wheezing and will not initiate/will terminate any physical activity such as jumping on the trampoline. If there is any educational testing or historical records I review these carefully, as well as discuss the child's cognitive development with the parent and teacher. After I have met with the parents for an initial session I will meet with both the child and parent(s) together. I explain the rules of my office and take some time to join with the child and orient them to my office before asking the child and parent to do a cooperative rice tray (usually I ask them to show me a picture of something they enjoy doing together). I then get a contract from the child to work hard in therapy. I usually teach the butterfly hug, which is a self soothing technique using bilateral stimulation and give the homework assignment of practicing it every night before bed. I always ask parents to label the two behaviors of the child that are most troubling to them. After the initial session, I carefully evaluate the tests, biography, family history, presenting problems, and my impressions as I set treatment goals. I also write a story for each child, based on their history to present in the rice-tray. The story is usually about an animal and I have found that when the child is ready, they begin to recognize the story as their own. Educating parents about attachment and attachment needs of their child comprise a significant amount of each session. I often refer parents to a support group.

Informed Consent-

I explain and outline procedures which will be used and have parents signed a document stating they have been informed. Some of the procedures reviewed are DDP, holding by the parent only (in a fashion similar to holding an infant but without swaddling or coercion), bottle feeding, eye contact, following direction practice, feeling identification, use of the rice tray, EMDR, anatomical dolls, truth-teller's/liars club, narrative story telling, calming and relaxation techniques, cognitive interweave and resource installation.

Safety/risk Management-

The psychological, emotional and physical safety of the client and any family member, is my first priority in every session. As I review the rules for my office the first rule is that no one, or nothing, ever gets hurt. If I see that a child or parent is dysregulating I will lead them in breathing exercise and suggest and provide appropriate ways to deal with their emotions. I always have a parent present in the room when doing attachment therapy and if there is any indication that someone's safety is placed at risk, an intervention is terminated. The only holding that occurs in my office is between the parent and child, without coercion of any kind. All interventions are consistent with the Standards of Practice, and Ethical Standards of ATTACH, the White Paper on Coercion and the Parenting Manual.

Evaluation/Outcomes/follow-up-Progress is measured subjectively by how the parents, teachers (and others) and child experience changes in the child's behavior. Progress is measured objectively by use of the symptom checklist to track changes, by evaluating steps in conscience development and the child's turning to the parent for comfort, social referencing and affect regulation. I also look for the child's ability to accept and give empathy, ability to accept and initiate repair, ability to mold in parents' arms, ability to seek non-stress related interactions. Follow up is handled by periodic phone calls to check in with the family.

Qualifications-

BSN 1972, worked 15 years in pediatric hospital nursing (licensed 1972-present)

MA in counseling, 1987(licensed 1993-present). Continuing education courses and trainings.