Individual and Family CHOICES Program
2214 North Atherton Street, Suite 4
State College, PA 16803
(814) 237-0567

Attachment Focused Family Therapy conducted by Lois A. Ehrmann PhD, LPC, NCC

Philosophy:

I believe that a healthy attachment to a loving and trustworthy caregiver is essential to the full development and health of the individual. Attachment can be defined as a special interaction between an individual and his or her caregiver in which the individual feels safe and trusts that his or her needs will be sensitively met in a fairly reasonable time by the caregiver. This trusting relationship evolves to the point that the individual feels more and more secure over time and due to this sense of security he or she ventures out into the environment to further develop and grow. In the absence of such an attachment an individual risks impairment in subsequent relationships because the blueprint or internal working model regarding how healthy relationships should operate is missing. Given my belief about the importance of attachment in the holistic development of the human being, when a person has attachment challenges, my preferred modality of treatment is family counseling. Within the context of family counseling I attempt to facilitate healthy and honest communication between family members and to provide safe non-threatening moments of healthy corrective emotional and healthy corrective cognitive experiences.

While I work with many different kinds of families in my general practice, my ***attachment focused family counseling*** work has mainly focused on families who have adopted or are fostering a previously traumatized child. Occasionally I will make an exception on this guideline and accept into the attachment focused family counseling caseload the biological child of a family and those family members who have been evaluated by myself and/or others to be healthy enough to risk the formulation of the attachment of the child onto the adults. This has been a rare occurrence in the past but clinical experience has demonstrated to me that there are some biological parents who through recovery and often 12 step support group involvement do become healthy enough to do this rather rigorous healing work with their birth children.

Description of Processes:

Intake/Admission:

When a family member (usually an adoptive or foster parent) calls to inquire about the treatment services I provide, an initial phone assessment is conducted to ascertain if I have the competency needed to assist this particular family. If I discern that I do not have the right competency level I refer the family to another resource such as the Attachment and Bonding Center of Ohio formally directed by Dr. Greg Keck, Cheryl Walters, Licensed Psychologist and Registered ATTACh Clinician in Lancaster, PA, or another appropriate facility that is within reasonable distance from the family. If I discern that I have the competency level to work with the family and if I have openings, I will offer the parents (no children for this initial meeting please) a brief face to face screening appointment that

usually lasts approximately 45 to 60 minutes. **There is no fee for this brief face to face screening.** This courtesy on my part allows parents to see if I appear to have the personality and skills that form a good match between myself and their family and it gives the parents a chance to ask me about the methods I use as well as the training I have obtained. If the parents are in agreement that they would like to obtain treatment services from me, I then set up a formal consultation with both parents. This consultation lasts for approximately 90 minutes and serves as a time for me to gather basic information regarding the history of the child, the parents' history both prior to and after the child's placement into their home and past successful or unsuccessful treatment interventions. I will also have the parents talk to each other about what they are feeling about our interview and the pending intervention and I will coach them into getting more attuned with each other emotionally as a way for them to experience some of the methodology or strategies that I use with adoptive and foster families. If after the brief screening appointment, and the initial 90 minute consultation, the parents feel comfortable with me and the methodology, we make an appointment for me to see the child for about a 90 minute session and I give the parents an incredible amount of paperwork/ surveys and assessment tools to fill out including Release of Information forms for all prior records related to their child and themselves. Parents (and I do mean both if there are two of them) are required to obtain and read one of the following books as well: *Adopting the Hurt Child: Hope for Families with Special Needs Kids* by Greg Keck and Regina Kupeckney, *Facilitating Developmental Attachment* by Dan Hughes, *Attaching in Adoption: Practical Tools for Today's Parents* by Deborah Gray; *Hope for Healing: A Parent's Guide to Trauma and Attachment by ATTACh*. If parents have read other books related to this topic such might be acceptable as well. Parents are encouraged to show me the books they have read so that I can make that determination.

Assessment:

I will see the child for 60-90 minutes to assess level of functioning in the areas of cognition, affective processes, behavioral issues, and educational issues. The child and I talk about prior experiences in earlier placements, prior treatment, and the events that occurred within the context of their birth families. My assessment of the child not only includes the data that I receive directly from the time spent with the child but also is informed from surveys and assessment tools filled out by both parents and the children themselves if they are able. Records from other agencies are also obtained and reviewed. Both parents typically fill out the following assessment tools in regard to their child: Achenbach Child Behavior Checklist (CBCL) or the Behavior Assessment System for Children, 2nd edition (BASC-2); the Spence Anxiety Scale; the Parenting Stress Index (children) (PSI) or the Stress Index for Parents of Adolescent (SIPA) both by Abidin; Family Environment Scale by Moos and Moos (FES); ADHD Rating Scale IV; other medical and demographic questionnaires. In regard to themselves and their

relationship, parents fill out the following: Trauma Symptom Inventory-2(TSI-2; John Briere), Beck Depression Scale (BSI); Dyadic Adjustment Scale (DAS) (marital/couple relationship quality), Family Assessment Measure – III (FAM-III), Dissociative Experiences Scale (DES), Symptom Checklist -90.

If children show the capability of doing so they fill out one or more of the following measures: Child Depression Inventory (CDI), Reynolds Adolescent Depression Scale –II (RADS-II) , Trauma Symptom Checklist for Children (TSCC; John Briere), Spence Anxiety Scale, Youth Reports from the Achenbach CBCL Series of assessments.

Children are also administered the IVA+ continuous performance test and neurofeedback brain wave baselines are conducted.

Depending on the individual situation, other tools may also be used. Included in the demographic data form are questions pertaining to social history, education history, attachment history, intellectual and cognitive skills and deficits history, psychological history, medical history, family functioning, treatment history, and developmental history. Assessment of the child and the family system may take up to four sessions in order to get a clear picture of the needs of the child and all other family members.

Treatment Planning:

Upon the completion of the assessment phase, I meet with the parents to discuss what I see as the needs of the child and what my recommendations are. At this point the parents and I decide the level at which to include the child in the treatment planning process. Younger children may not be able to sit through the entire treatment planning process but older children and certainly adolescents are encouraged to be an active part of the treatment planning process where concrete goals, objectives and strategies are identified and time guidelines established. For the older child/ adolescent the Formal Treatment Plan becomes a contract that everyone has input into and is reevaluated every 60 days. When a child is younger the terms of the treatment plan are simplified and he or she is asked if he or she is willing to work with his or her parents in order to get along better and to be a happier, healthier family. It is important to understand that in attachment focused family therapy the family attachment relationships are the client and not the individual child or individual family members.

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Treatment Techniques Used:

While I use many attachment focused techniques and strategies to work with children and their families I also generously use techniques that come from cognitive behavioral models (CBT), family systems theory, narrative approaches, and interpersonal relationships theories. I also do quite a bit of behavioral rehearsal, role playing, imagery and visualization with children and their families. The use of art and play therapy as well as sand tray play therapy techniques when appropriate have also been used by me in working with children with attachment and other behavioral issues. I have also found the use of the Internal Family Systems Model developed by Richard Schwartz to be especially helpful to both children and parents when processing issues related to past abuse and neglect. I have been trained in all three levels of Internal Family Systems as well as the Somatic Internal Family Systems Approach. I am a certified clinician in this approach found to be especially helpful for individuals struggling with trauma.

Upon completion of the assessment and treatment planning phases, I usually only see the child within the context of his or her family. Therefore most of the time parents are always present working with me and their child as part of a team. An exception to this may be when working with older children and teenagers. If the team including the child identifies that trauma resolution via the use of Eye Movement Desensitization Reprocessing (EMDR explained later in section) is warranted those sessions may include the child only.

Very important to the treatment that I provide and essential to the healing process for all family members is the sense of humor and curious wonderment that is eternally part of my therapeutic stance. Emotional warmth and caring acceptance for all family members are also integral aspects of treatment in my practice. Be forewarned however, that emotional warmth and caring acceptance is for each ***individual human being*** and not necessarily for behaviors that are destructive or divisive to the person or the family relationships. Children in my caseload learn rather quickly that I will care deeply about them but confront squarely inappropriate and destructive behaviors. On another level I should clarify that unlike other treatment modalities I am not that interested in forming an alliance with the child. In fact I will often verbalize that I do not really care whether or not a child bonds to me or likes me. My objective in this type of therapy is to facilitate the bonding and attachment between the child and his or her parents. Interestingly enough when I have been successful in the facilitation of that goal, children have always verbalized that they had a keen understanding that I cared deeply about them.

In addition, I facilitate both verbal and written contracts between children and their parents as well as teach parents how to do nurturing rituals with their children both in and outside of the session room. I do not generally hold children mainly because I do not want them to become too attached to me but rather if the child is willing (and by the way most are) I encourage parents to engage in nurturing safe loving cradling of their children

regardless of age. If the child is not comfortable with this or absolutely refuses the child is never coerced into being held or cradled. I have found that whether the child voluntarily allows cradling or holding or refuses such does not matter in the family healing process.

Frequently within family sessions behavioral management solutions are discussed and usually I facilitate parents and children in agreeing to a contract that gets evaluated in the next session. Frequently I also facilitate the use of forgiveness rituals, amends making, journaling for both children and parents, and role playing. There are times when I request parents to come in on their own or as a couple if I feel that they are stuck in some way and that family healing is blocked. If periodically coming in to work with me does not move the family healing process along, I will request that a parent or parents accept a referral for individual or couple counseling and then will work with that professional to get the process moving again. Parents accepted into my caseload for attachment focused family therapy may be encouraged and or referred to take part in the Self-Led Parenting Therapy Group which was developed and field tested in 2008 by Lois Ehrmann and Carol McFall. Initial measure results showed positive outcomes for parents who were struggling with the behaviors and woundedness of special needs children whether fostered, adopted or biological. Participation in this group for parents may become mandatory if therapy has become blocked due to parental activation in response to children's behaviors. In addition you should understand that if I request that you engage in individual or couple counseling as part of the overall family therapy protocol and you refuse to do so I will terminate my services to your family. You should definitely ask me questions about this if you are confused in any way about this information. Occasionally I will have separate sessions for siblings within the family if they are in need of some special attention.

Occasionally children will regress to an earlier stage of development due to not getting their needs met sufficiently in an earlier placement or within their birth family. I have baby bottles and toys available for such times but this is never forced. Most children welcome the chance to regress safely and request they be 'babied' for a little while in session. No child is ever shamed for this request. Art work and exercises are often used as well as music and books. Often the child and his or her parents and I will help the child develop a narrative about some issue in his or her life and we will at times make the narrative into a book.

I have completed formal training and am a certified therapist and approved consultant (EMDRIA) in Eye Movement Desensitization Reprocessing (EMDR) which consists of a set of strategies that helps the brain of a traumatized individual digest and thus resolve traumatic memories more effectively and completely. I continue to voluntarily have clinical consultation in the use of EMDR and will ask parents and children to sign permission for me to consult with my trainer/consultant on their situation if need be. If I

believe that EMDR might be helpful to a child I will explain the process in depth and give written information to the parents to read. We will then discuss this topic more completely at that or a later time.

There are some techniques that you may have read about in the attachment literature on the Internet or in older books about attachment issues. Some of these techniques have been cited as being dangerous and in fact have caused physical harm to children. The following techniques will **never occur** in the therapy room within my practice: adults laying on children, blanket wraps or compression holds, deliberate causing of physical discomfort, deliberately frightening a child, forced feeding of water or any other substance for that matter to children, parents observing from another room.

In January of 2008 I engaged in neurofeedback (EEG biofeedback) training and I am currently being supervised in the provision of such services to children and adults who have brain regulatory issues. Brain regulatory issues are indicated in the following issues or problems: Posttraumatic Stress Disorder, Attention Deficit Hyperactivity Disorder (with or without hyperactivity), unipolar and bipolar depression, attachment difficulties. As I assess your child as well as the family functioning if I believe that neurofeedback training would be helpful I will further discuss this option with you as part of an integrated treatment protocol.

I have also thoroughly researched body centered, somatosensory, and energy therapies because these strategies have also been found to help individuals heal from traumatic incidents or experiences. Trauma is often held in the cellular level of the body and therapies such as Cranial Sacral therapy and therapeutic massage treatments have been found to assist in the healing of traumatic physical and emotional injury. The body energy meridians known for centuries as part of Chinese and/or other Eastern Medicine Systems have now been systematically studied in the western world. Treatments such as acupuncture and acupressure have risen from these traditional systems of healing and have been found to be helpful for many different issues. These body/energy centered therapies are available to the families receiving services at CHOICES and may be recommended although never mandated.

I am also certified in Clinical Hypnosis (ASCH) and interspersed in my treatment for both adults and children I will often use guided imagery or narrative stories to assist with healing from trauma and abuse.

Safety/risk management plan:

The methods that I use in working with attachment issues are non-coercive although they can be somewhat intrusive. When I say intrusive what I mean is that I encourage and directly coach family members to have direct eye contact, sit closely to talk sensitively

about issues and encourage soft gentle touch via hand holding or a hand on a shoulder. For this reason I always work with parents in the room (except as mentioned before when using EMDR with older children and teenagers) and we make decisions as a team. The understanding is that our goal is always to do no harm and that the therapy room is a place where problems can be discussed honestly and feelings can be expressed freely in a safe way.

All of the adults in the room are responsible for making sure that the physical and psychological safety of the child is never compromised. No child shall ever be restrained or have pressure placed on them that would interfere with their basic life functions such as breathing, circulation, temperature etc.

If physical touch is used the touches will always be caring ones that do not harm or hurt and will never be sexual in nature.

Therapeutic interventions will be carefully selected by the child's team which includes the parents and therapist as well as other possible treatment providers such as psychiatrists, case managers, and school counselors.

No form of shaming, demeaning, or degrading interaction is acceptable as a therapeutic intervention.

Very rarely, in discussing issues between children and parents, a child may begin to express anger that becomes out of his or her control. If a child begins to rage in the session, (i.e. physically hitting parents or therapist, throwing objects in the room, trying to flee out the door or window) the adults will move all items away from the child so that he or she will not get harmed. Verbal instructions to the child will be given to direct the child in ways to deescalate the rage without physical restraint. If the child begins to act in ways that will hurt him or herself (pinching self, biting self, etc), parents will gently try to assist the child in getting into control by providing comforting or soothing behaviors as well as holding the child's hand to prevent self harm. The therapist will attempt to assist the child with his or her anger by encouraging the child to use his or her words or to use other techniques that are safe to discharge the rage (i.e. hit or kick a pillow safely, rip or crumble paper, jump on small boxes etc.). If the child begins to physically attack his or her parents or the therapist, parents will gently hold the child in as nurturing a way as is possible and continued gentle verbalizations encouraging the child to take deep breaths and to use words to describe anger will continue. Usually these actions on the part of caring adults assist the child into better regulation of his or her affect and resolution is achieved. Although this type of scenario is **NEVER** stimulated, desired, manipulated, or promoted, when this happens naturally this can be one of the most potent types of corrective emotional and corrective cognitive experiences for the child and the family.

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The child experiences that the adults who care about him or her will assist him or her through most likely very valid rage and anger and will not reject, abandon, or abuse him or her. Parents experience that they can stay present with their child through the storm of intense affect and that staying with the child through the encounter in a safe way is possible. In staying present to the child and affirming his or her strong feelings, resolution is often accomplished.

If a child remains out of control, the therapist along with the parents will decide whether a call to emergency services is in order and if so the Centre County Crises Services will be called to assess whether hospitalization is warranted for the child. This has never happened in my practice but this service does exist and can and should be utilized for the safety of a child or adolescent.

Evaluation/outcomes/follow-up:

Progress is evaluated on each client via the treatment plan review that occurs every 60-90 days. At that time parents and children (if appropriate) are asked to identify the ways in which there has been improvement and the status of achievement of goals. In addition the ways in which current strategies may not be working and therefore need to be changed will is also discussed. In addition toward the end of treatment parents are requested to fill out another Achenbach Child Behavior Checklist and other relevant assessment instruments. The scores from this termination phase are compared to the scores at the time of Intake and Assessment and this is shared with the child as a sign of improvement and growth. After discharge at three, six, and twelve months, brief questionnaires are sent to the family to inquire about how the child and the family are functioning. This questionnaire process is documented in the child's file and is part of our formalized follow up procedure.

Please review now the Informed Consent attached. Sign two copies. You keep one and the other gets returned to us with all the other assessment instruments.

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INFORMED CONSENT FOR THE PROVISION OF ATTACHMENT FOCUSED FAMILY COUNSELING

Child's Name:_____ Date of Birth:_____

I/We do seek and consent to participate in the **attachment focused family counseling** work that Lois Ehrmann or one of her associates provides at the Individual and Family CHOICES Program (subsequently identified as CHOICES in the remainder of this document) (address above). We have reviewed the document titled Treatment Protocol related to Attachment Issues –Rev. 7/19/2012 and have also reviewed her training hours and credentials specifically related to attachment issues and trauma resolution. (All of these documents are also available at the website: www.individualandfamilychoices.com).

***Parents and Child if over 14 initial here:_____

The treatment model is based on principles of Attachment Theory (Bowlby, 1969) which postulates that the relationship between the child and his or her primary caregiver is of the utmost importance in the healthy development and resilience of the child. The attachment focused work that Lois Ehrmann or her associates do is specially focused on traumatized maltreated children who have been adopted into another family. Some exceptions to this may be made on an individual basis. Check here if you are a birth parent accepted into the attachment focused family therapy program____. In addition Lois Ehrmann and her associates also specialize in adopted children who were exposed prenatally to substances while in their birth mothers' wombs. Her credentials and training in addictions work uniquely support this specialty area.

***Parents and Child if over 14 initial here: _____

I/We have been advised that the overall treatment experience may include the following: Evaluations, assessments, individual/parental/couple/family/Self-Led Parenting Therapy Group counseling, Eye Movement Desensitization Reprocessing (EMDR), Neurofeedback (NFB), and Internal Family Systems Therapy (IFS), adjunct supplemental services such as referral for medication evaluation and or referral for sensory integration or other body centered therapies; referral for one or both parents to additional therapists in order to work through personal issues if they are sabotaging the attachment focused work; treatment planning and treatment plan review; parent and child education regarding attachment and other relevant issues such as trauma, grief and loss, prenatal exposure to drugs and alcohol; other pertinent issues or factors that may need to be addressed by the child's team (parents, therapists, psychiatrist, school or wrap around counselors etc.) at the time.

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I/We understand that the services will be provided and coordinated by Lois Ehrmann or her associates at CHOICES and I/We understand that no outcomes of effectiveness of techniques or services can be guaranteed although Lois has done extensive research in this area and can provide us with sources for any information we might desire. Associates working with family members in the attachment focused family therapy program are supervised directly by Lois Ehrmann.

In addition techniques and strategies may include:

1. Coaching all family members regarding the loving caring use of eye contact, soothing physical touch, gentle voice tones, nurturing hugs and cradling holding. There interventions or strategies are never used to threaten, intimidate, or coerce a child in any way.
2. Behavioral contracting both verbal and written, brain storming to promote problem solving abilities and to resolve family conflicts, facilitation of restitution (making amends) for hurting someone or property, modeling and support for risk taking.
3. Humor and playfulness in the way of skits, role plays, dramatizations, over exaggeration, art and music to light heartedly and sensitively make a point are generously used in every family counseling session.
4. When appropriate children and families may also be coached to write a narrative or book about the experiences that they have had and included in the narrative are usually pictures that also drawn by the family members working in team fashion. Time lines and life books are also used if appropriate to the family's needs and existing material is incorporated into the session time.
5. Cognitive behavioral techniques that have been proven helpful in shifting the family members' thinking patterns into healthier frame of reference.

Elements of therapeutic parenting which can be reviewed in Dan Hughes' books on facilitation of developmental attachment, Grey's book Attaching in Adoption, and Hope for Healing by ATTACh will be used. Parents are requested to read a number of books or articles in order to further understand and support their children.

***Parents and Child if over 14 initial here:_____

Techniques that will never be used by Lois Ehrmann or her associates at CHOICES include the following:

Forced holding of a child or adolescent, blanket wrap holds or adults lying on top of a child, holding a child in order to provoke an emotional response, shaming or deliberately

eliciting fear in a child, poking or provocation to force a response in a child/adolescent, coercing a child to engage in long or painful physical activities in order to force compliance or a response, blaming a child for his or her rage, isolation of child in a room for lengthy periods of time, any technique that appears to have potential risks for the child's emotional, psychological or physical well-being.

***Parents and Child if over 14 initial here:_____

I/We understand that if during family counseling our child escalates emotionally and begins to physically lash out at any one in the session room or begins to damage objects within the room, all adults will remain calm and will use verbal instructions to assist the child in calming down. A monitored time out may also be used. If the child begins engaging in behavior that is physically hurtful to him or herself or others I/We as the child's parents will gently hold the child in a cradling nurturing manner and present to the child strategies to calm and soothe. As soon as the child is no longer at risk of self or other harm, he or she will be permitted to stand up, get a drink, go for a monitored walk if desired. I/We understand that this type of event occurs very infrequently.

***Parents and Child if over 14 initial here:_____

Key to the promotion of healthy parent child attachment and bonding is the health and security of the parents in the family. I/We understand that if during the course of the attachment focused family therapy, I/ We encounter personal or couple issues that are sabotaging the forward moment of the attachment focused family therapy with our child, I/We will consent to a referral to another counselor for resolution of those issues and will sign full release of information forms for all therapists involved with our family to consult and strategize together for the best interest of our family. I/We also understand that while not mandated I/We are strongly encouraged to partake and engage in the Self Led Parenting Therapy Group that Lois Ehrmann and her associates facilitate on a weekly basis. I/We understand that Lois Ehrmann and her associates have the right to terminate services to our family if I/We refuse to accept a referral and engage in the recommended therapy.

***Parents and Child if over 14 initial here:_____

I/We are aware that the practice of professional counseling or therapy is not an exact science and no guarantees have been made to me/us as a result of any work with Lois Ehrmann or her associates. I/We have also been informed that our participation in this counseling arrangement is totally voluntary and that I/We may withdraw from this program at any time, simply by informing Lois Ehrmann or her associates. In the same

vein Lois Ehrmann or her associates will be honest regarding her/their expertise and competency levels and if at any time she/they feel that I/we would be better served at

another facility or different level of care Lois or her associates will inform us verbally and in writing and will assist us in obtaining the treatment protocols necessary.

***Parents and Child if over 14 initial here:_____

At times video or audio taping of sessions is helpful in reviewing progress and or in treatment strategizing. In addition Lois Ehrmann and her associates responsibly obtain clinical supervision/consultation and use of video taped sessions are sometimes needed for review and intervention planning with the consultant/supervisor. Therefore I/We give permission for such recording to be used for this purpose only.

***Parents and Child if over 14 initial here:_____

I We acknowledge that we have been informed that the hourly rate of attachment focused family therapy is $100.00 per hour and that payment of co-pays of insurance are payable at the time of the session appointment. In addition sessions can last anywhere from 60 minutes -180 minutes (3 hours). Also if insurance does not reimburse for services in a timely manner I/We understand that we will pay the fees in full.

I/We acknowledge that the services and treatment protocols have been fully explained and that we have had our questions adequately answered. I/We also acknowledge that I /We have received a copy of the CHOICES Informed Consent which includes statements of clients' rights. A grievance procedure is also posted in the waiting area in the event that I/We feel we have been treated unfairly or unjustly in any way.

***Parents and Child if over 14 initial here:_____

Signature of Parent/Guardians: Date:

Signature of Child if older then 14 years of age:

Witness:

Assigned Therapist:

Parents received a copy of this Informed Consent Document ____ yes _____no
Child if over 14 years of age received a copy of this Informed Consent Document ____yes _____no