

Treatment Protocol
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We are a group of therapists in the Seattle area, each with a private practice, who consult, refer and work with one another frequently. Some of us share an office suite and work under the name Adoption Therapy Associates of West Seattle. All of us see primarily foster and adopted children and their adoptive families to treat issues related to attachment and trauma. This protocol is meant to be a basic framework that enables us to structure our approach to working with our clients but it is not a one-size-fits-all model.

Screening:

Potential clients generally make initial contact via phone or internet/email. Clinician screens clients based on their stated needs, referring out when necessary, (i.e. the need, severity, risk factors, type of services requested, financial resources or time frame do not match the clinician's availability, skill set or scope of practice). We keep a comprehensive list of excellent referrals including other therapists and other allied professionals.

Therapy Process, Initial Assessment/Intake:

3-6 Sessions with parents only (generally) for kids under 13-years-old and/or kids who are developmentally under 13. Adolescents may be included in initial sessions or may be seen alone if that is clinically indicated.

Parent Only Assessment Sessions: Sessions 1-2

- During these sessions we define parental concerns and goals for treatment.
- Collect a full demographic, attachment and psychosocial history of parents, including use of AAI and other interview-based methods as indicated.
- Discussion of family resources and supports, areas of stress and vulnerability.
- Full history of child, including family of origin history, dates of last contact, termination of rights information, prenatal exposure risk, prenatal care and birth history, developmental course, mental health and medical history, medications, placements history, educational and academic functioning .

- Review of all available records of past therapy/counseling, court documents, police records, previous psychological and/or neuropsychiatric assessments, relevant medical records, adoption homestudy, Individual Education Plans and any other type of evaluation. (This work may be done outside of sessions). Reviewing this information allows the clinician to form a more comprehensive and complete picture of a child with a complex past.
- In-depth discussion with parents of experience of parenting and how it may differ from what they expected, with goal of building rapport and overall support for therapy process.

Parent Only PsychoEducation Sessions: Sessions 3-6

- Aid parents in developing an understanding of attachment as a process, and of the impact of complex and relational trauma, as well as other ACE's, on attachment and behavior.
- Provide Parent Self-Care handout packet, from ARC Model by Blaustein and Kinniburgh (see Parent Handout Packet).
- Develop understanding of aberrant behaviors in terms of attempts to get needs met, control the situation, etc.
- Discuss concept of creating a secure base.
- Discuss management of parent/caregiver affect, attunement, interactive emotional repair, consistent response and importance of routine and ritual (high nurture, high structure), and other BRAIN BASED parenting strategies.
- Assess parent's reflective capacity and begin to work with parents on concepts of intersubjective connection and communication, (how to talk with kids about their past in a healing way).
- Work with parents on "mapping" child, identifying and understanding trauma triggers, fight/flight/freeze response, emotional regulation strategies, *strategies for sleep* and other challenging areas.
- Complete (with parents) other child assessment measures that *may be indicated*, i.e. Child Behavioral Checklist, BASC, IPPA, Beck Depression Scale, Beck Anxiety Scale, Child Dissociative Scale, Vanderbilt Assessment Scales for ADHD (for purposes of referring for further evaluation), Autism Behavior Checklist if indicated (for purposes of referring for further evaluation), etc.
- Provide resources for further understanding of impact of trauma for children, i.e. books (see list), video series such as Children From Hard Places (Karyn Purvis), etc.
- Provide a list of clinical and support resources to parents for any additional diagnostic findings beyond the scope of our services.

Initial Session(s) Diagnostic & Treatment Planning with Child and Parents Together:

- Introduce treatment to child; build rapport with use of "big mammal body language," (getting close while being safe) and tone of voice. Observe dynamics through family games. Observe

for any areas that may require further evaluation (sensory-motor issues, speech, language skills, etc.)

-Use of projective drawings may be done to explore how the child thinks and feels about his/her family and self.

-A visual treatment plan drawing is created with the child; a simple grid with 4-6 treatment goals drawn, in order to clarify what will be worked on (and what will not be addressed - no surprises). This is collaborative with the child, while also specifically addressing identified problems and presenting issues.

-Addressing any resistance in the child by discussing the pros (and cons) of working on change.

Beginning Therapy Sessions with Child and Parents Together: 2 Sessions

-Work on establishing safety and security, acknowledgement of fears. (Start to overcome the assumption of danger that many children have). It is helpful for some children to have the plan for the session spelled out on a dry-erase board, for example: 1) Check in, 2) Drawing, 3) Practice Cuddles with Mom, 4) Go Home

-Build affect identification and vocabulary; help child name feelings and find them in his/her body. Use of body drawings/maps. Use of feelings cards or visual charts, and games that help name feelings.

Formulation/Diagnostic Review and Treatment Plan with Parents Only (for kids under 13):

-A session is done around this time to provide parents with an overall assessment, diagnosis and formulation, as well as a complete written treatment plan. Parents will have an opportunity to ask questions and clarify goals.

-Any safety issues associated with treatment, as well as plans for safety outside the sessions, are addressed in the treatment plan. For example, if it is anticipated that a young child may need to be physically restrained at some point during treatment for their own safety, those safe restraint techniques are taught to parents at this time. If a child has a history of doing self-harm or otherwise posing a danger to themselves or others, plans for safety are discussed with parents at this time, including crisis management and respite options.

-At this point, any missing assessment information that would be of benefit, as well as indicated adjunct services, i.e. psych evals, medical evals, speech/hearing, O.T. or P.T. are recommended and/or followed up.

-At this time, therapist is in contact with other providers, (school staff, social workers, pediatricians, etc.) as indicated and/or is requesting relevant records from either the parents or the appropriate providers. Parents will be asked to review and sign a Release of Information form prior to requesting records or consultations from other providers.

Framework Setting Sessions with Child and Parents Together: 4-8 Sessions

- These sessions will focus on setting the structure for future sessions; if tolerable to the child, clinician will meet with parents for first few minutes of each session in order to regulate them, then have child enter a calm and welcoming situation.
- During these sessions some time is devoted to being physically close with parents; children may practice cuddling, may engage with parents in active (but not frenetic) play, may do some structured filial play activities, practice gazing, singing, feeding, drawing together, building legos, etc.
- For children who have not had a consistent caregiver, and those who need developmental catch up, some baby and toddler play may be done. Children who are reluctant may be asked to stretch their limits a bit at a time, i.e. "Can you sit with Mom until I count to 5?" At no time is any coercive holding technique used.
- Address concept of "family," for those children who have lived in institutional care and/or those who don't have the concept. Use of "magic circle," "family portrait puzzles," and so forth to build concept of family as people who go together and care for one another.
- Work on use of parent for assistance and emotional comfort. Reciprocal emotional repair after conflict.
- When safety is established, work with the child will begin to focus on building self-regulation skills; belly breathing, use of sensory tools such as bean bags, fidgets, simple mindfulness exercises with parent support, coaching.
- For school age and up therapist will teach concept of fight/flight/freeze & body's alarm system, "flipping your lid," and relate to "trauma triggers." May talk about "trauma glasses," teach child to take own pulse, do a feelings inventory, etc., in order to build competency and self-management skills.
- Work on being a "feelings detective," begin to identify more complex emotions in self and in other. Connect body sensations to thoughts, emotions and behaviors.
- May work with books such as What To Do When You Worry Too Much, (Huebner), What To Do When Your Temper Flares, and other such illustrated guides and workbooks for children.
- Work should focus on what the family and child needs; if it isn't broken, don't fix it.

Routine Treatment Review Parent-only Sessions:

- Beyond initial assessment and framework sessions, occasional meetings will be scheduled with parents alone, (if child is over 13, have them sign a release) every 6-8 weeks to discuss parenting challenges, assess treatment plan progress, and update treatment plan.

Multiple Sessions with Child and Parents Together to Address Affect Regulation, Competency, Trauma, Grief and Identity (ARC Model):

Affect/Emotional Regulation:

- Modulation: work on ability to up-regulate and down-regulate, i.e. How Does Your Engine Run, rev the engine and put on the brakes when needed.
- Work on affective expression, i.e. be congruent and fluent with expressions of feeling states, wants, needs. (See ARC Model).
- Parents continue work on attunement and joining children in expression of feelings, creating and confirming safety.
- Children are aided in identifying safe people, safe ways to communicate, address non-verbal communication, body language, etc., building a repertoire of effective self-expression skills.

Competency:

- Address issues of self-esteem and competency (ARC Model), identification, development and strengthening of internal and external resources. Develop positive ties and relationships to culture and community. Achieve felt mastery and success in areas that will support ongoing growth, relationships and coherent positive sense of self.
- Attend to executive functioning issues and related family/school stresses.
- Address Identity (unique self, positive self, coherent self and sense of self in the future - ARC Model)
- Essentially, achieve a good-enough developmental track and trajectory and sense of self.

Trauma Work:

Children will arrive in therapy at different stages of development and different stages of trauma consolidation. Each therapy must be tailored to the individual child's needs, and with the goal of creating a more coherent narrative of the *self* versus focusing on all the details of the story. These sessions will include some segments of "work" and some of "play." What follows is a general overview of what *work* at this stage might include:

- Assist family and child in formulating an understanding of current behaviors in the context of past traumas.
- Assist the child in connecting how current "problematic" behaviors and actions, thoughts, physiological experiences, ways of/problems with relating, models of self and other, etc. are related to the emotional experiences of the past (shame, helplessness, fear, rage, loss of attachment, etc.). Work to recognize how certain behaviors may have been excellent strategies for survival in the past, but no longer work well in the present.
- Address immediate overwhelming memories, intrusive thoughts, behaviors related to PTSD and/or relational trauma. Through use of attachment, developing reflective capacity (and/or use of the parent's reflective capacity) and techniques learned so far to deal with these experiences. Use of modulation strategies and self-soothing.

- Create visual narrative or timeline with child. May involve a scroll drawing, creating a book, telling a story, playing out the story with dolls or figures, etc. Use of photographs, court documents, letters, adoption papers, etc. may be incorporated to provide exposure and to establish the timeline. Using this timeline will become a means/place to make sense of a jumble of memories and to sort out internal story, make facts explicit, address shame, identify and address core cognitions/conclusions about self and other. Use narrative to look for, name and normalize predominant themes associated with developmental trauma.
- Use of multiple modalities to process traumatic content, i.e. be drawing and talking at the same time, or talking and writing, or other modalities that work for the child to integrate their experiences.
- Distinguishing 'then' from 'now'. Connecting feelings, behaviors and experiences in the now to events and experiences of the past. Consider what is different now from before, in terms of resources, protections, options, actions.
- Consider expectations of caregivers in past in contrast to what can be expected from caregivers and other relationships now. Work on developing a functional internal working model of self and other.
- Development of reflective capacity and empathy in the child by (therapist and parent) carefully targeting and consistently responding empathetically to the child's need(s) that underlie hostile, controlling and/or dissociative behavior, and providing meaningful help.
- For some children, trauma and/or adverse circumstances occurred prior to the formation of explicit memory. Work with these children will include narrative but may focus more on tolerating and managing affective and sensory experiences and development of internal resources via attending to attachment.

Addressing Grief and Loss:

- Naming and grieving specific list of losses. May create a grief box or other art therapy technique.
- Addressing loyalty conflicts - how can I love my birth parents and my adoptive parents, etc.
- Resolving fantasies and fears.
- Contextualizing how things are now for child and how things may be for past family/families.
- Forgiveness work - forming realistic perspectives on what happened and why, resolving anger and fear from the past, becoming present.
- Identifying strengths and feelings to keep, as well as behaviors/ways of coping and feelings that are no longer helpful to maintain.
- Rituals for remembering and rituals for releasing.
- Establishing or maintaining relationships/open adoption issues.

Integration/Identity Sessions:

- Trauma work involves many aspects of identity and bringing together various parts of the self. After trauma integration there may be a need for more in-depth work on issues related to personal identity (including cultural, racial, sexual, other).
- Establishment of identity as a family.

- Exploration of self and multiple aspects of self within the context of, and apart from, history.
- Development of a sense of self with ability to move forward into the future. Creation of a vision of self in future.

Maintenance and Drop In Sessions:

- Clients may return at key points of development after initial work is done in order to renegotiate, update or go deeper in the work with greater capacity.

Termination (3-6 sessions):

- Clinicians acknowledge and affirm with clients when treatment goals are met throughout the therapy, and discuss termination as a natural and positive outcome as it draws closer. Some form of small but formalized celebration is often indicated, especially for younger children.
- Terminations are planned with families and are not abrupt whenever possible, so as not to resemble past abandonments or traumatic endings. Clinicians may advise families in considering the impact of premature endings, in the context of the child's history, while also respecting the needs and wishes of the family.
- As termination process takes place over several sessions, attachments with parents are reaffirmed as a source of ongoing support. Personal strengths, internal and external resources are reiterated and affirmed.
- Specific plans are made for continuing self care and growth, as well as to address any safety issues. Plans and referrals are made for any further services for care that may be indicated.
- Discussion takes place on how and when client may wish to return to therapy. Normalize this process, as many clients will need to return as they encounter new stages of development and/or life challenges.
- Should a course of treatment end abruptly, i.e. client(s) stops attending sessions without prior arrangement, a letter is sent to the client(s), documenting that they have stopped attending sessions, and detailing how they might return for sessions and/or be referred for other services if needed. Referrals may be included in the letter if indicated.

Safety/Risk Management Plan:

We address in the treatment plan phase the safety needs of everyone in the family including pets. Treatment plans include parental education about the unique characteristics of children with attachment disorders including:

1. Splitting and how triangulation can undermine the attachment between caregiver and child
2. Role of traumatic triggers which lead to behavioral issues rather than opposition and defiance

3. Explain how chronic dysregulation from unresolved trauma can be misinterpreted as ADHD

Also, important is coordination of care with other service providers. Coordination is important to insure all service providers present a unified approach and do not work at cross-purposes. Isolated families are at a much higher risk of child abuse, out of home placements, disruptions and/or dissolutions. Planning also include respite and other supports. It is important to build meaningful and lasting supports that will help the family long-term.

At no time during treatment are any coercive holding techniques or aggressive *in-your-face* confrontation techniques used. These types of techniques are contraindicated and can be further damaging to vulnerable children.

Physical restraint is extremely rare in our offices with children and is used as a last-resort measure employed exclusively for the purposes of keeping a child safe from self-harm or harm to others. Restraint is never used as a *technique* in the therapy. It is employed only by those who have had appropriate training in the safe use of physical restraint with children of various ages. At all times during a physical restraint, therapist monitors child's breathing, temperature and basic life functions. Restraint is ended as soon as the child regains control of their body and is deemed able to be safe again.

The use of touch by the therapist in sessions is done with care, sensitivity and thoughtful rationale on the part of the therapist, always with the informed consent of the client(s), and with the goal of developing, supporting and advancing the attachment between the parent and the child, in accordance with the agreed upon treatment plan for that child. Each therapist follows their code of professional ethics in the use of touch with clients.

Evaluations/outcomes/follow-up:

-Treatment plan review and tracking of progress in therapy is a constant part of the therapy process with children within the sessions as goals are met and achievements celebrated. A more formal review of treatment progress is done periodically with parents in parent-only sessions (when appropriate) in order to keep the process on track and collaborate on changes over time.

-Frequently we see clients for more than one course of therapy over time, and so are able to observe how the child is developing. Issues that were not primary in past courses of therapy may be addressed in subsequent courses, as they arise with new developmental stages. For example, teens who were seen as young children may return to do deeper work on identity issues as they prepare for emancipation.

-Clients are invited to complete an online survey at the end of treatment in order to provide feedback on what was helpful and what was not.

A Note About Clinician Competency, Supervision and Consultation:

As a group of clinicians, we share the conviction that each of us has a responsibility to continue to gain education in the field, specifically in areas of attachment and trauma competency, as well as to be accountable in terms of maintaining ethical standards. We all adhere to Washington State standards and requirements regarding Continuing Education and strive to enhance our knowledge of current research and evidence based practices.

In fact, we met through taking post-graduate certificate programs in Adoption and Foster Care Therapy, and Attachment Trauma-Focused Therapy, with Deborah Gray, MSW. We are committed to regular peer consultation with one another as well as supervised consultation with Deborah Gray and other senior professionals. As a group, we often work together, through consulting, writing and speaking, to further our own professional development and ensure the quality of our work.