TREATMENT MODEL

Over the past five years I have actively worked with treatment and parenting for children with problems secondary to abuse, neglect, and multiple placements. I have worked with and trained under Dr. Lark Eshleman, Ph.D. at the Institute for Children & Families in Lancaster, PA. Dr. Eshleman's Synergistic Trauma and Attachment Therapy® model considers the combination of therapeutic interventions that together provides a greater positive effect than the sum of each part. Treatment is also based on Dyadic Developmental Psychotherapy, a treatment model developed by Dr. Daniel Hughes, Ph. D. It is based on the premise that the development of children and youth is dependent upon and highly influenced by the nature of the parent-child relationship. Such a relationship, especially with regard to the child's attachment security and emotional development, requires ongoing, dyadic (reciprocal) experiences between parent and child. The parent is attuned to the child's subjective experience, makes sense of those experiences, and communicates them back to the child. This is done with playfulness, acceptance, curiosity, and empathy. These interactions are contingent, i.e., when the parent initiates an interaction, the child's response determines the parent's subsequent action based on the feedback of the child's subjective experience of the first action. In that way, the parent constantly fine-tunes his/her interactions to best fit the needs of the child. The primary context in which such dyadic interchanges occur is one of real and felt safety. Without such actual and perceived safety, the child's neurological, emotional, cognitive, and behavioral functioning is compromised.

When a child's early attachment history consists of abuse, neglect, and/or multiple placements, s/he has failed to experience the dyadic interactions that are necessary for normal development and s/he often has a reduced readiness and ability to participate in such experiences. Many children, when placed in a foster or adoptive home that provides appropriate parenting, are able to learn, day by day, how to engage in and benefit from the he dyadic experiences provided by the new parent. Other children, have been much more traumatized and compromised in those aspects of their development that require these dyadic experiences, have much greater difficulty responding to their new parents. For these children, specialized parenting and treatment is often required.

For such treatment and parenting to be effective they much be based on parenting principles that facilitate security of attachments and which incorporate an attitude based on playfulness, acceptance, curiosity, and empathy ["PACE"]. The foundation of these interventions--both in home and in treatment--must incorporate the above principles and never involve coercion, threat, intimidation, and the use of power to force submission.

The following represents a list of general principles that are characteristic of the treatment and parenting model and, I believe, congruent with attachment and trauma literature:

1. Eye contact, voice tone, touch (including nurturing-holding), movement, and gestures are actively employed to communicate safety, acceptance, curiosity, playfulness, and empathy, and never threat or coercion. These interactions are reciprocal, not coerced.

2. Opportunities for enjoyment and laughter, play and fun, are provided unconditionally throughout everyday with the child.

3. Decisions are made for the purpose of providing success, not failure.

4. Successes become the basis for the development of age-appropriate skills.

5. The child's symptoms or problems are accepted and contained. The child is shown how these simply reflect his history. They are often associated with shame which must be reduced by the adult's response to the behavior.

6. The child's resistance to parenting and treatment interventions is responded to with acceptance, curiosity, and empathy.

7. Skills are developed in a patient manner, accepting and celebrating "baby-steps" as well as developmental plateaus.

8. The adult's emotional self-regulation abilities must serve as a model for the child.

9. The child needs to be able to make sense of his/her history and current functioning. The understood reasons are not excuses, but rather they are realities necessary to understand the developing self and current struggles.

10. The adults must constantly strive to have empathy for the child and to never forget that, given his/her history, s/he is doing the best s/he can.

11. The child's avoidance and controlling behaviors are survival skills developed under conditions of overwhelming trauma. They will decrease as a sense of safety increases, and while they may need to be addressed, this is not done with anger, withdrawal or love, or shame.

12. The child may be held at home or in therapy for the purpose of containment and safety when the child is in a dysregulated, out-of-control state only when less active means of containment are not successful in helping him/her regain control, and only as long as the child remain in that state. The

therapist/parent's primary goal is to insure that the child is safe and feels safe. The goal is never to provoke a negative emotional response or to scold or discipline the child but rather to help him to become safe and regulate his distress through the parents accepting and confident manner.

It is easier to list interventions that I never use in therapy nor recommend that a parent use at home then to list all of the possible interventions that I might use. I am confident that all interventions I use are consistent with principles of attachment and trauma theory and research.

The following interventions are NEVER used:

1. Holding a child and confronting him/her with anger.
2. Holding a child to provoke a negative emotional response.
3. Holding a child until s/he complies with a demand.
4. Hitting a child.
5. Poking a child on any part of his/her body to get a response.
6. Pressing against "pressure points" to get a response.
7. Covering a child's mouth/nose with one's hand to get a response.
8. Making a child repeatedly kick with his/her legs until s/he responds.
9. Wrapping a child in a blanket and lying on top of him/her.
10. Any actions based on power/submission, done repeatedly, until the child complies.
11. Any actions that utilize shame and fear to elicit compliance.
12. "Firing" a child from treatment because s/he is not compliant.
13. Punishing a child at home for being "fired" from treatment.
14. Sarcasm, such as saying "sad for you," when the adult actually feels no empathy.
15. Laughing at a child over the consequences which are being given for his behavior.

16. Labeling the child as a "boarder" rather than as one's child.

17. "German shepherd training," which bases the relationship on total obedience.

18. Depriving a child of any of the basic necessities, for example, food or sleep.

19. Blaming the child for one's own rage at the child.

20. Interpreting the child's behaviors as meaning that "s/he does not want to be part of the family," which then elicits consequences such as:

    A. Being sent away to live until s/he complies.

    B. Being put in a tent in the yard until s/he complies.

    C. Having to live in his/her bedroom until s/he complies.

    D. Having to eat in the basement/on the floor until s/he complies.

    E. Having "peanut butter" meals until s/he complies.

    F. Having to sit motionless until s/he complies.

Giving the above consequences in a "loving, friendly tone" does not make them appropriate. The tone may actually cause greater confusion about the meaning of love, parenting, and safety which we want children to understand. If an interventionism not on that list, I may or may not use. A rule of thumb is always that the intervention is something that is congruent with how secure attachments are formed and how traumas are resolved. If one is still uncertain, please contact me rather that assuming that I would recommend that intervention.

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