The Treatment Milieu: What it is & What to do.

Training Motto 1:
You can have 30 years of experience or you can have one year of experience 30 times.

Training Motto 2:
A child will hear for the 1st time what you have said for the 20th time.

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Module 1.
What is Milieu Based Treatment?

There are 4 components that entail Milieu Based Treatment.

Component 1. Appropriate living environment
Provide a living atmosphere that is predictable, consistent (in that staff always respond to particular behaviours, but in a way that is suitable to the situation), non-punitive, safe, and structured.

Helpful Hint:
Remember the 3 F's. Fair, Firm and Flexible!

Steps to Effective Limit Setting
We spend most of our time doing it, so we might as well learn to do it well.
1. Label specifically what behaviour is not okay. Don't assume they know.
2. Label why it is not okay. Don't assume they know.
3. Give the positive choice first.
4. Give the negative choice last.
5. Allow time.
6. Debrief with the client after they have made a choice.

Principles of Effective Consequencing
1. The consequence must flow from the behaviour.
2. The consequence must provide the caregiver leverage for gaining compliance.
3. The consequence must be clear and enforceable and the caregiver must be prepared to follow through.
4. Consequences must be immediate, if possible, and closed ended.
5. The consequence must leave room to increase if it is needed.
6. Do not consequence to discipline behaviours that occur in environments that have (or should have) their own code of conduct.

Helpful Hints:
Presentation is Everything!
This means delivering the message (along with the consequence) so that the kid's best interest is at the heart of the intervention and not the adults' personal reactivity to the kid's behaviour.

Be neutral, objective and reflective.

At all cost – avoid the CYC cadence.

Remember your UMAB training. There are 4 things staff can do with their bodies (and therefore their ***presentation****) to decrease the potential of an aggressive response.*

1. *Voice - tone and quality.*
2. *Physical distance to the client.*
3. *Body language.*
4. *Eye contact with the client.*

Component 2. <u>Providing corrective/therapeutic experiences</u>

-Corrective is better than before, promotes further personal development, and broadly fits with social expectations.

-Therapeutic is helping the child work through the negative impact on them (that is, how they think, feel and behave) of their previous experiences.

<u>Helpful Hint</u>.

- Always do what is corrective.

- When you can, do what is therapeutic. Some of the factors that define "when you can" are: do you understand what makes the intervention therapeutic?; is the situation right for this intervention at this time?; is the child open to it?

Component 3. <u>Individualized treatment planning</u>

-Understand that every person is an individual and that it is their subjective "take" on what has happened to them that matters, and has influenced their development.

<u>Helpful Hint</u>.

Assume Nothing! A Staff members' "take" on any given situation does not matter. It is the what the child thinks, feels or remembers that is important. Ask Questions!

One of our founding principles for doing the work that we do is to ***"Know your Kids"****.*

Component 4. <u>Coordinating modifications to treatment plans</u>

-As treatment strategy is implemented, modifications to the plan are often required. It is important that no decisions are taken in isolation. Everything is based on a team approach, with communication to all team members. Any intervention implemented is done in a planned and informed way, and with the purpose of being helpful to the child.

<u>Helpful Hint</u>

Keep these questions in mind: "Why am I doing what I am doing?"
"How does it fit with providing a corrective/therapeutic experience?"

-The child must be included and informed of the treatment plan as much as is useful for them so that issues that are dealt with and processed are done using the treatment plan as a frame of reference. Work would need to be done to translate the treatment plan into terms that the child can use and at a time that is right for the child.

-Staff must recognize that putting issues on the table and discussing aspects of the child's treatment may be destabilizing to the child for a time, but must be understood to be part of the therapeutic process and should not be avoided. De-stabilization may look like various things such as: tension and conflict between staff and child; escalation of symptomatic behaviour as well as subjective distress on the part of the child. It can also include deterioration of their ability to cope at school or in the community.

Helpful Hint
Keep in mind that de-stabilization does not necessarily mean that the treatment is not working, particularly if this response is understandable in the context of our formulation of the child.

Myth - Treatment progress equals stable behaviour.
Actually - Periods of de-stabilization are often indicators of progress.

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Module 2.
What Tools do we use to accomplish the A,B,C And D of Milieu Based Treatment?

Use of reflection versus self-disclosure
-Staff self-disclosures might be misunderstood and misused by the child, rendering the staff ineffective.
-Child may experience staff as selfish, self-involved, punitive, lecturing and out of touch, and this may recapitulate the child's experience.
-Children need to talk about themselves and they need to feel heard. Reflection allows this to happen.
-Self-disclosure "muddies the water" and takes away from the child's experience.
-Self- disclosure is not useful either as a corrective or therapeutic intervention. Reflection focuses on the affective state that the child is experiencing.

Helpful Hint.
Keep in mind that a child will not feel heard or understood when they are being bored or enticed by the life experiences of the staff members.
Myth – self- disclosure helps to join with the children or validates the children's experiences.
Actually – Self- disclosure often does little more than make staff feel admired and liked or smart and insightful.
Reflection.......
-Puts words to feelings that the kid might not presently have the words for.
-Taps the underlying emotional meaning of the words.
-Looks underneath words and behaviours for affective meaning.
-Doesn't focus on surface behaviours, but on the themes of the behaviours.

Reflection is not....
-Linear or content focused.
-A parroting of the kids' words.
-A way to confirm your own hypothesis.
-A way to force your own ideas on a kid, which often leads to a self-fulfilling prophecy.

Common Themes that hide underneath the words and behaviours.
"This isn't fair"
"You aren't understanding me"
"I'm really scared about what is happening to ...me...my siblings...my parents."
"It's hard to trust you with my thoughts & feelings."
"You are judging me".
"This reminds me of the time when I was.....being lectured...being abused...being ridiculed."

Other common themes to reflect.
"I'm not important enough to be liked".
"I'm not important enough to be looked after".

"I'm not important enough to be thought about when I'm not in your sight".
"I'm not important enough to be noticed unless I'm really loud or acting up".

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Module 3.
Understanding and Treating Behaviours and Symptoms - and knowing which is which.

Behaviours Versus Symptoms
Children living within a treatment environment will demonstrate behavioural manifestations of their experiences, anxieties, traumas and issues. Some of this behaviour may be directly related to learned, although dysfunctional coping strategies, or to situational variables. Some, however, may be symptomatic representations of underlying factors. These two things may look the same on the surface. However, they should not be treated in the same manner. It is essential to differentiate between symptoms and behaviours.

Behaviours are...........................
more consciously-based, more under voluntary control; driven by a variety of factors such as functional purposes, secondary gain, modeling, previous learning; present-focused; driven by current need.

Symptoms are........................
manifestation of underlying causes; past-focused; less conscious; less under voluntary control; driven by history.

Why is it important to know the difference?
The ability to differentiate between the two is the fundamental difference between a psychologically comprehensive treatment approach and simply providing a safe environment for children.

With Behaviours.............
various concrete, here-and-now, direct approaches can be used such as natural and logical consequencing, various behavioural modification techniques, skills development, and modeling.

With Symptoms...........
there is a need to address and attempt to resolve underlying causes. Some of the mechanisms to do this are to ensure basic safety, process the issues, including communicating a desire to understand his/her actions and feelings, and convey a sense of validation of their experience, and active listening.

When symptomatic behaviour is not harmful or threatening the overall safety of the child, the message can be given that we do not expect the symptomatic behaviour to go away until.........
-we understand what it means.
-we have provided a more healthy way to deal with the distress or anxiety.

<u>Indicators of symptoms</u>
-Symptoms are not responsive to behaviour modification.
-The behaviour is a symbolic or direct representation of traumatic past experiences based on what you know of the social and family history.
-There is an affective overtone to the behaviour that indicates that there is something more underlying the behaviour.

<u>Helpful Hint.</u>

When you get frustrated - then get informed. Frustration means you do not have enough information

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Module 4:

<u>How to Read a File</u>

<u>When reading a file, focus on...</u>
-pulling out what is important and discerning what is not useful or no longer relevant.
-make and develop predictions about what might be a child's thoughts, feelings and behaviours with the goal to understand the child's experience and symptoms/behaviours.
-this is important because we know that certain experiences affect development in certain ways. With our population of children, these are some of the issues.

Word of Warning.....
It is not uncommon for the same issue or experience to show itself in opposite kinds of behaviour.

<u>Helpful Hint.</u>
Keep in mind that each child is an individual and the same history with different children may have very different effects (or show their effects differently). Do not use a "cookbook" approach to formulating your thoughts and plans. Ex. A child that has experienced physical abuse may show the effect by being overly cautious and timid, or may show risk-taking behaviour.

Types of life experiences that contribute to the problems that we see.

The following is a list of experiences that might be common to our clients.
Look for them (or indications of them) when reading through file information.

Cautionary Note!!
This list is not comprehensive and is intended to be used only as a guide.

1. Multiple caregivers and discontinuity of care
-which can lead to:
undermined trust in caregivers; over self-reliance; indiscriminate interactions with others; a damaged attachment capacity.

Examples of what you might see.
Two possible extremes.
1st Possibility
-child who views the world as against them and does not see value in engaging in meaningful relationships- child is hostile, suspicious, and mistrusting.

2nd Possibility
-child who seems to want to connect with everyone, and seems to quickly form connections, and who talks about people with whom they have not had a chance to form a relationship "as if" they have known them forever, or "as if" they would like to know them forever. These are the "as if" kids. They can make staff (and other people) feel "as if" they are very important to them (the child) or that the staff (or other people) is the only ones who can help. This does not fit with the reality of the situation.

You will often get a mixed bag of behaviours where they will present in one way in a given situation and radically change how they react in a different situation because they are fearful, mistrustful or cannot tolerate emotional intimacy.

2. Neglect
-which can lead to:
withdrawal from the world and development of a depressive view/mood, with little or no hope for the future, a "who cares" attitude and feelings of unworthiness.

Example - Deprivation can lead to a limiting of affective range where children generally only experience sadness, anger, or emptiness and they cannot take pleasure in pleasurable experiences.

3. Abuse: emotional, physical, sexual
-which can lead to:
"driven" behaviour where the child re-enacts previous experiences, and/or the child is highly invested in avoiding any situation or feeling state that is a reminder of their past abusive experiences. Such reactions are indicators of trauma.

-Such abuse can also impact perceptions of self, as well as perceptions and expectations of others (that is, it affects what they believe about how others see them, and what they believe about how they will be treated by others).
-The child's capacity to regulate their emotions is impaired, particularly once they have been aroused. The capacity to self-soothe might be damaged.

To clarify - Children make assumptions about how others will treat them and how they will be perceived by others and these assumptions colour the interactions so that the children do not experience the reality of the situation, but experience the situation according to the preconceived expectations they have formulated.

Helpful Hint:
It is important to understand as much as possible about the abuse scenarios, and how the child experienced these events. This knowledge helps us avoid recapitulating the circumstances of abuse, allows us to identify triggers and understand the child's symbolic behaviours, as well as their reactions to what otherwise would seem to be neutral events.

4. Transience
-changes of home and school, which can lead to:
-lack of achievement motivation, because there is a sense that nothing is permanent.

Example - Child does not invest in anything (relationships, personal belongings, activities, learning or accomplishments) as their experience is that nothing lasts.

5. Poverty
-which can lead to:
-feelings of deprivation, a focus on material needs, envy as a prevalent emotion, intense but short-lived interest in possessions, and once attained, a lack of appreciation for what was initially desired.

Example - Child seeks immediate gratification often through food or other basic sources of gratification (whatever makes you feel good), and will often over-indulge and have a belief that if you don't take what you can now, it will not be there tomorrow. May view others that are "getting" what they want with jealousy and with a sense that "if they get, then I have to go without".

6. Parental substance abuse
- which can lead to:
-mixed messages about taking medication, a focus on externalizing blame or responsibility and not feeling accountable for one's own actions or situation (external locus of control), identification with substance abusing parent or subculture.

Example 1 - The child believes that only external factors can control or manage behaviour or emotions, and there is no sense of internal control over feelings or actions. "I need my medication". There might be a defiant outlook that might sound like, " If it was good enough for

my mom or dad, it is good enough for me". There can also be a sense of hopeless inevitability that a certain outcome will happen, "it's just a matter of time".
Or, "I'm just like my mom/dad". There also might be a sense of identification with family or a family system. This can lead to participation in that family's life-style (such as addiction) as part of a "right of passage" and "proof" of their belonging.

Example 2 - In order to create a sense of control, the child might assume care giving functions, or might have a hyper-vigilante orientation to the environment.

7. Domestic violence
-which can lead to:
-internalization of blame ("it's my fault", or "I need to fix it"). It is important to note that witnessing violence, particularly to a primary caregiver, is vicarious trauma, which can be as emotionally disruptive as being the direct victim of the violence.

Example - Creates a template for the cycle of abuse in relationships whereby the victim takes ownership over the abuser's feelings and actions.
"If I would have just not ....then he/she would not have ....".

A child who witnesses violence may also develop a belief that the abuser is justified in the abusive behaviour; that is, the victim "deserved" the abuse.

"If only he/she had gotten the meal on the table/ shut up/ been nice........., they would not have gotten beaten up".

8. Criminal subculture in family
-which can lead to:
-non-acceptance of mainstream authority-figures, and disregard for conventional/pro-social standards of behaviour.

Example - The "screw you" attitude where there is no belief or commitment to accepting social standards and expectations and no regard for conventional social rules, including the need to respect the rights of others. These children do not look up to or use those in authority as role models and do not esteem the opinions of those in authority to be valuable or needed. This can develop into a sub-culture and pervades a child's outlook.

9. Dysfunctional family system
-which can lead to:
-intra-familial dynamics can be so pervasive that the individual will often try to recreate the system within any new environment. This is typically unconsciously organized. This can take many forms such as: assuming inappropriate roles within the living environment; confusion around parent/child roles and responsibilities; hierarchy problems and distorted executive functioning; sibling conflict (around perceived preferential treatment or victimization); suicidal gestures or other self-destructive actions.

Example - Parentification of a child and /or crossing of generational boundaries to assume roles inappropriate to the age or developmental stage of the child.

10. Serious psychopathology

-mental disorders, which can lead to:
-constitutionally-based vulnerabilities, which make the child less able to cope effectively; and may lead to identification with the "crazy" parent.

Example - A child has a predisposition to a biologically based disorder if there is a family history of constitutionally-based mental health difficulties. The child can also develop a "self-fulfilling prophecy" orientation regarding the belief that what happens or whatever they do confirms their expectations that they will end up like the "crazy parent".

The psychological expectation that "I'm going to end up like my crazy parent" can happen regardless of whether the parent's mental disorder is constitutionally based or psychogenic (that is, caused by psychological factors such as all those discussed in today's training.)

11. Biological/Prenatal factors

Cognitive and emotional capacity can be impacted by biological factors (prenatal substance abuse, genetic loading, early brain trauma, such as arising from birth difficulties, shaken baby syndrome, malnutrition).

-which can lead to:
constitutionally-based vulnerabilities, such as an over-aroused physiological system, predisposition to learning difficulties or disabilities, temperamental factors that complicate the caregiving process.

bonding difficulties, that is, a parent's problem emotionally connecting with or appropriately caring for the child as the parent is afraid of damaging the child, or the parent is unable to tolerate a tempermentally difficult child.

Review of file information for Clinical Case Conference:

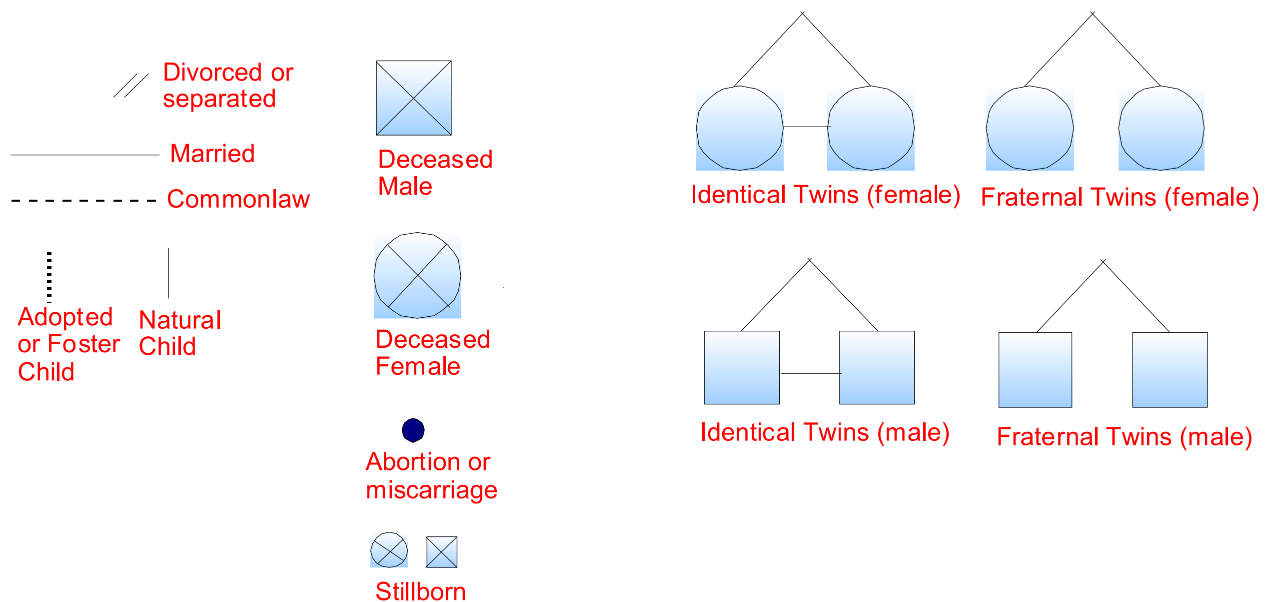
Components of a Clinical Case Conference

1. Genogram
2. Life line
3. Current functioning
4. School functioning
5. Family contact
6. Review of recent assessment
7. Formulation

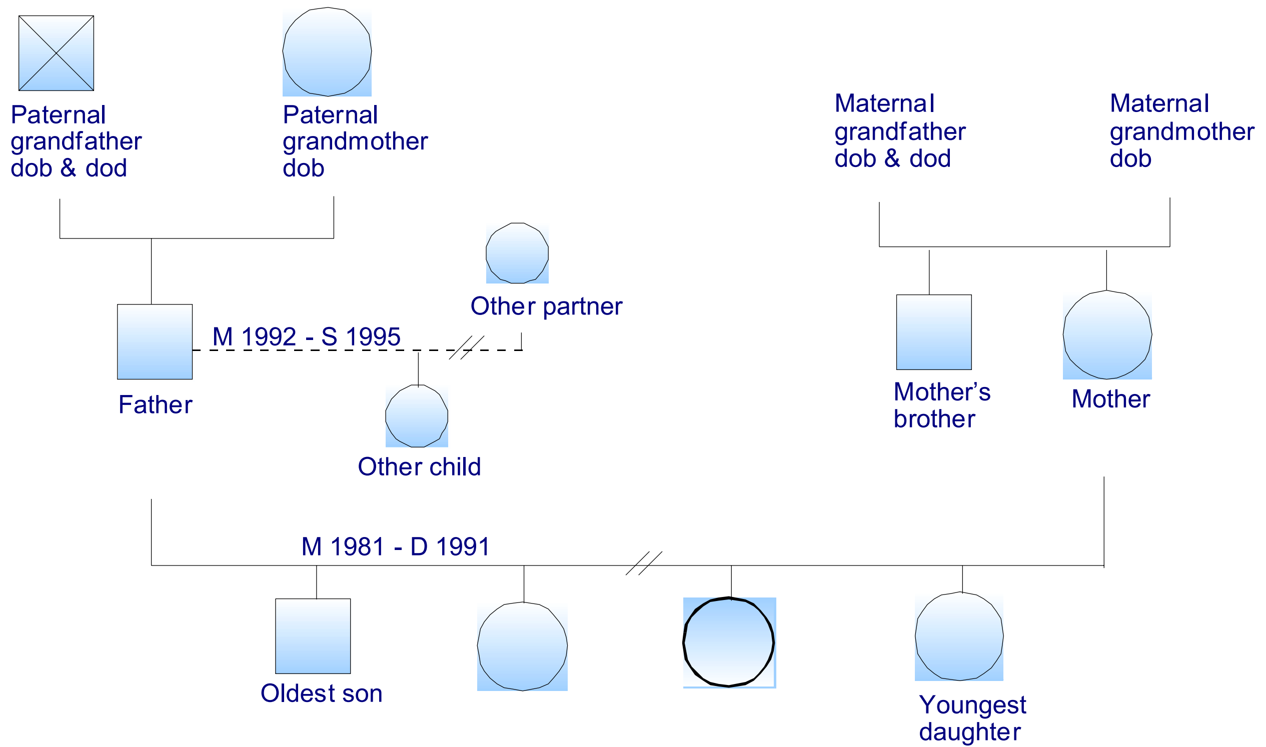
Genogram
Elements to include, but are not limited to:
-all important players in the family system across generations (include constellation of the foster family and the parenting style of the foster parents, when length of placement has been significant).

Discuss the genogram from the top down, and each individual as a person, including the nature of their relationships with other family members. Include significant dates such as formation and dissolving of unions and why, traumatizing and important events (including positive achievements or experiences).

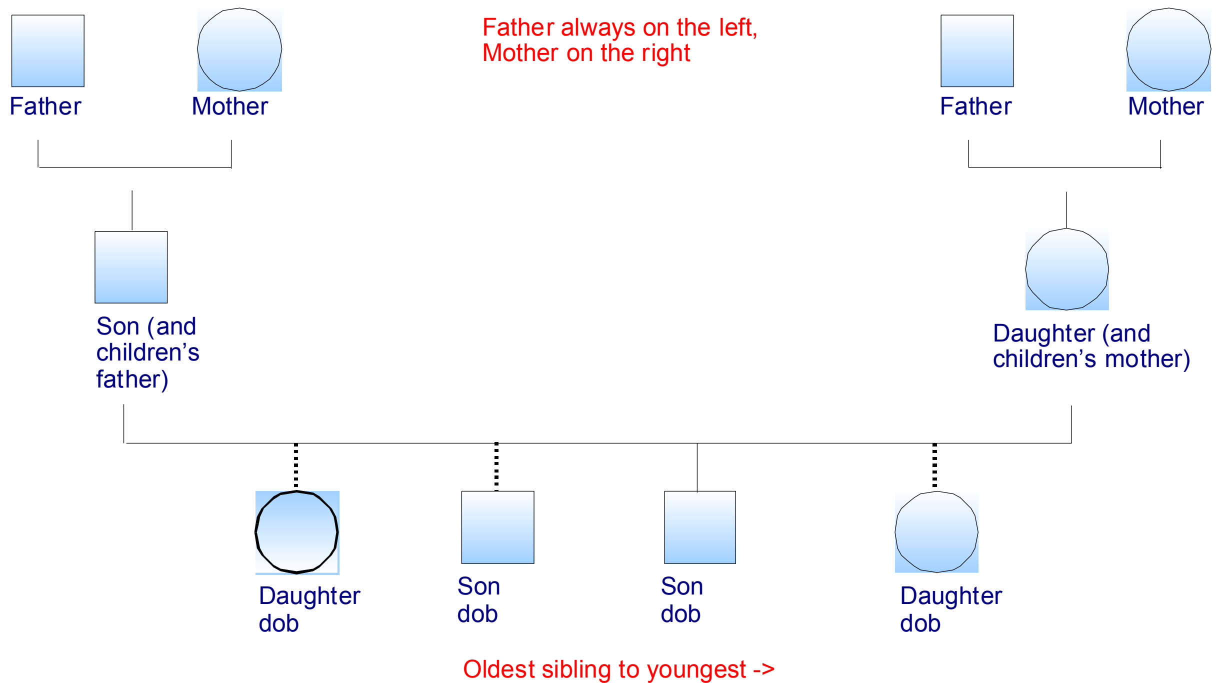
GENOGRAM ATTRIBUTES



FAMILY GENOGRAM MODEL A



FAMILY GENOGRAM MODEL B



Lifeline.
A chronological representation of the family and individual history of the child. Include significant (both positive and negative) life events with an awareness of developmental status (meaning what is the differential impact of these events on the child given the developmental stage that the child was in at the time).

Separations, births, deaths, moves, incarcerations and hospitalizations, changes in family make up as players leave and new ones are introduced. We need to outline the information with an outlook to what is psychologically significant to the child to assist us in understanding the child's experience.

This section can be divided into two or three categories and researched by two to three people depending on the amount of information present and the complexity of the case. However, the information should be presented in chronological order with the "expert" filling in the information at the appropriate point.

History of life events:
A chronological outline of psychologically significant events including (but not limited to) births, deaths, abuse (who, where, why and how), relationships (how they start and end), moves (and reasons for the moves), and anything else that will help us understand how the child views the world.

History of placements:
How was it experienced by the child;, child management strategies of the foster parents or care-givers

History of intervention:
Including what happened (eg. medication, therapy, assessments), when, why and what was the outcome of the intervention.

Current Functioning
This is not a report on surface behaviours. The goal is to track presenting problems or initial presentation according to which "behaviours" have increased, decreased, or stayed the same, and to identify newly emerging "behaviours"(colour coding is a useful tool to assist in identifying particular patterns and shifts) . There should be an attempt to tie significant changes in the functioning and presentation of the child to life events/stressors/changes that might account for the changes in the child.

School Functioning
This is not a report on surface behaviours. The goal is to track presenting problems or initial presentation according to which "behaviours" have increased, decreased, or stayed the same, and to identify newly emerging "behaviours"(colour coding is a useful tool to assist in identifying particular patterns and shifts). There should be an attempt to tie significant changes in the functioning and presentation of the child to life events/stressors/changes that might account for the changes in the child.

Also:
Note basic facts of school placement: grade level, nature of program, specialized placement.

Family Contact
This is not a report on surface behaviours. The goal is to track presenting problems or initial presentation according to which "behaviours" have increased, decreased, or stayed the same, and to identify newly emerging "behaviours"(colour coding is a useful tool to assist in identifying particular patterns and shifts) . There should be an attempt to tie significant changes in the functioning and presentation of the child to life events/stressors/changes that might account for the changes in the child.

Also:
Note facts of the visit (format of visit such as location, supervision, time frame and those present, changes over time and for what reason), and reactivity (both positive, negative or neutral) around contact (pre and post contact).

Review of Recent Assessment
By the Consulting Psychologist with a view to understanding treatment recommendations or other findings based on the nature of the assessment.
There are a variety of different assessments that can be done with our clients. It is important to understand what they are (and are not) so that the information is not misunderstood or used inappropriately.

-Treatment Readiness Assessment.
To determine whether a client is capable and/or prepared to make use of individual psychotherapy.

-Personality Assessment.
To assess the child's emotional and internal life, with a view to understanding underlying conflicts and issues, defensive style, and other aspects of psychological functioning. This facilitates the case formulation and planning..

-Cognitive Assessment.
To assess various aspects of cognitive functioning, with a focus on implications for educational planning.

-Comprehensive Psychological Assessment.
Combines features of personality and cognitive assessments.

-Parenting Capacity Assessment.
To assess a parent's ability to parent, in the context of the specific parent-child relationship; to assess a parent's capacity to change and utilize therapeutic and other interventions. This may facilitate wardship and access planning.

Formulation
The purpose of the formulation is to develop an informed treatment plan wherein elements of that plan are congruent with the needs of the child.

Formulation - **The 4 P's**
Arrived at by compiling and understanding all of the background material (with a view to identifying **predisposing**, **perpetuating**, **precipitating** and **protective** factors) for the purpose of developing an understanding of the child's personality development, symptom formation, and behavioural style in order to formulate a comprehensive treatment plan.

Predisposing
What factors in the child's life has led them (or predisposed them) to view the world, relationships, themselves, adults, other peers, school, etc.... in a particular way?

Perpetuating
What factors in the child's life has allowed this view to continue or to be perpetuated?

Precipitating
What factors in the child's life seem to cause or precipitate certain responses?

Protective
What factors in the child's life have been protective in promoting or maintaining the strengths that the child presently has?