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Building and Evidence-based Clinical Practice

Eliana Gil, Ph.D.

I travel across the country doing workshops on a variety of topics related to child and family play therapy and interpersonal complex trauma in children. On average, I have done about 15 national and international trainings for the last ten years or so—more prior to that time. Providing workshops allows me to interact with large numbers of mental health professionals, and thus, I get a sense of "the pulse" of my colleagues, at least those mental health professionals working with high-risk children in a variety of private and public agency settings.

The questions I am most frequently asked of late are: 1) How do you provide ethical services in managed cared required timeframes?; 2) How do you respond to the pressure to provide evidence-based practices? and 3) How do you document play therapy practice to meet Medicare charting requirements? Finally, a growing chorus of my peers verbalize their concerns with being compelled to incorporate evidence-based practices when it is a given that no one model will work for everyone? Specifically, some colleagues speak of "being forced" to implement techniques that they find objectionable or less than useful.

Here are my current thoughts on these questions. Sometimes there are no clear-cut answers but at the very least considering them clarifies what we might be able to do as we meet these challenges.

1. *How do you provide ethical services in managed care required timeframes?*

It is difficult for me to respond to this because it has been a long time since I was in a work environment in which I was asked to provide therapy within brief therapy models. The closest I came was one or two work environments where myself and other staff were pressured to increase "billable hours," which by definition meant that we were being encouraged to see more and more clients, which had the end result of compromising the quality of services. Needless to say, I was not able to remain in these work environments. However, I can say that I hold firm on the belief that if our caseload is comprised of complex trauma cases, we have to limit the number we see, for the good of the clients as well as for our own self-care. I happen to believe that a caseload of 15-17 clients per week is about as large as a caseload should be when cases are complex trauma exclusively. These cases require more case management hours and they require more clinical self-care.

Regarding very brief timeframes, another way I've thought of this when I've been under the gun to do things more quickly (for example, when children are moving out-of-state or prior to judicial proceedings), I have kept in mind Herman's three phases of treatment. Specifically, she speaks about the first phase of treatment being absolutely necessary to proceed to trauma-specific work, and as we all know, in complex trauma cases, children's sense of safety and trust are often quite delicate—in addition, children often come to therapy quite dysregulated or constricted and addressing these coping strategies also takes time. Dr. Herman cautions about two big mistakes in treatment of trauma: 1) avoiding the subject of trauma altogether, and 2) rushing in too quickly prior to setting a therapy alliance. Thus, in very short-term treatment models, clinicians are encouraged to work on topics of self-regulation, safety, and reparation of trust. Regarding the processing of trauma, if it appears that children become receptive to listening to, or participating in verbal dialogues about the trauma itself, this can be undertaken carefully, but for the most part, my advice is to assess children carefully and make inroads into the topics of relationship, safety, trust and regulation. This will serve the child best when trauma work is approached later on. In my experience, children have been referred into brief episodes of therapy in revolving door fashion so that some children return for treatment services twice or more and receive the six to eight sessions included in the brief model.

2. *How do you respond to the pressure to provide evidence-based practices?*

I think this is a good thing: a useful challenge for us all. The pressure to incorporate evidence-based practices makes us review what we do and clarify and refine our practices. What I've done in my work is stay informed about the evidence-based practices that appear relevant to the work I do. These include: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (CPIT), Parent-Child Psychotherapy (PCP), EMDR (Eye-Movement Desensitization Reprocessing), Child-Parent Relationship Therapy (CPRT), Filial Therapy (FT), Mindfulness, and Theraplay (although the latter four are not formally considered EBTs although they have a great deal of research to show their effectiveness). I believe that in the next decade or so, we will likely be looking at common factors, the factors within therapy that cause change, and we will build competencies around those. In fact, watch for Schaefer and Drewes's new book (in press), in which they lay out update change agents which they believe are included in most play therapy practices. In the meantime, here is how we are choosing to describe our services at Gil Institute for Trauma Recovery and Education, LLC:

Gil Institute for Trauma Recovery and Education, LLC, provides treatment services to high-risk children and their families. Staff recognizes that treatment of complex trauma is a field of study that is evolving

quickly and is still in its earliest stages. Thus, we are committed to staying well-informed and conversant with new therapy approaches related to our target populations. Mental health services include evidence-based practices as well as practice-informed approaches based on theory, science, literature, and best practice guidelines. Staff maintains a strong commitment to individualized and developmentally-appropriate assessments that inform the creation of structured and goal-oriented treatment plans. Our clinical staff also recognizes the importance of the expressive therapies to facilitate affective discharge, to increase communication, and to process difficult traumatic experiences. Our treatment services recognize the individuality of each child and family member and the importance of understanding their phenomenological experience of events in their lives. We seek to provide treatment that is sensitive to developmental and gender differences, as well as cultural diversity. Treatment is practice and research-informed, forensically sensitive, provided within a multidisciplinary context when appropriate, and focused on promoting the strengths, resiliency, and best interests of each child and family .

Finally, Kazdin (2008) states that an evidence-based practice is a clinical practice that is informed by evidence about: (a) the effectiveness of specific interventions, (b) clinical expertise of the therapist, and (c) client needs, values and preferences. This appears to be the direction that the field is heading and most play therapists have embraced this approach.

3. *How do you document play therapy practice to meet Medicare charting requirements?*

I'm sorry to say that I am not a Medicare provider so I have not had to maintain the rigorous charting that has been described to me by those I supervise and work within Medicare-providing agencies. However, I must admit that the question of charting in general, specifically related to charting expressive therapies, remains a question or concern of many. For that reason, I will comment that charting is quite individualized and structured by agency requirements. However, I would encourage anyone attempting to describe the use of expressive therapies, to keep these simple variables in mind:

1) Be certain of your goals and maintain no more than three goals at any given time;
2) Be certain that your goals are measurable, that is, if you are looking to document that something is changing, you need to conceptualize how you will gauge change;
3) Make sure that play therapy techniques are chosen to *advance* goals that have been set and describe them that way. As an example of a brief progress note, consider the following:

Individual session with Selena (date, length). I followed up on our work from last week, choosing to focus on the goal of helping Selena decrease her worries. Last week we read a book about worries and Selena responded positively to one of the lessons about not growing the worry by not paying too much attention to it. Today, we did an art therapy exercise in

which Selena drew a picture of her worry, folded the page into fourths to make it small, and then decorated a box in which to store the worry. Selena seemed receptive to the idea that this therapist would "hold" the worry in the office so that she did not think about it too much. However, if she did find herself starting to worry, I asked her to make a small picture of the worry on a small post-it (which I provided) and she could bring to the next meeting so we could store. Selena left feeling optimistic and focused on a baseball game she has in a few days.
Plan: Continue to discuss her worries and assess whether her nightmares decrease in the coming week.

I continue to feel inspired by the creative work and study of many of my colleagues. Please feel free to contact me with your questions and ideas. We are all in this together!! Best, Eliana