

NRF Model Case:
The Power of Procedural Play
Using the NRF in Clinical Practice

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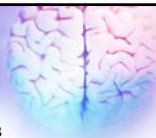
Connie Lillas, PhD, MFT, RN
www.the-nrf.com

Outline



- Review of NRF's Three Steps
- NRF Guiding Principles Review for Sensory-Motor Bottom Up Work
- Model Case #3, Enacting Procedural Memories Through Play (Relevance)
 - NRF Guiding Principles for Procedural Play
 - Integrated Cultural Awareness and Use of the Self
- Community Goals and Interest Groups

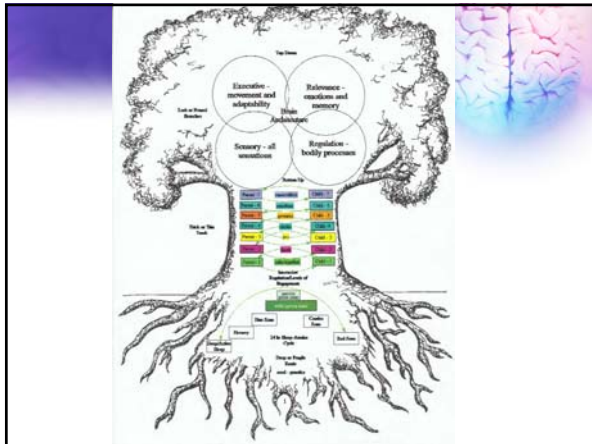
3 key concepts, 3 key steps



3 Key Concepts	3 Key Steps
<ul style="list-style-type: none">• Toxic stress disrupts early brain networks• Relational "serve and return" process builds strong circuits• Brain architecture is built upon lived experiences	<ul style="list-style-type: none">• #1 Reduce/eliminate toxic stress in relationships (roots)• #2 Improve the quality of engagement (trunk)• #3 Support individual differences & remediation of brain networks (branches)

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Questions #1-2 **7/15/16**

1. **FALSE** Stress responses are a clinical tool that are only useful for professionals not parents.

2. **FALSE** Top down strategies are good to start with in treatment because they teach much needed skills.

1. Pre= 95% Post= 100% Increase: 5%

1. Pre= 79% Post= 85% Increase: 6%

Questions #3-4 **7/15/16**

3. **FALSE** Traumatic experiences only impact the relevance system because that's the system involved with memories and emotions.

4. **TRUE** The regulation system includes the capacity for deep sleep, green zone and stress responses.

3. Pre= 92% Post= 88% Decrease: -4%

4. Pre= 95% Post= 97% Increase: 2%

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Questions #5-6

5. All of the following are examples of bottom up strategies except:
 A. Bouncing on an exercise ball
 B. Deep breathing
 C. **Identifying and labeling affect**
 D. Deep pressure/massage
 E. Dimming the lights and turning off extraneous sound

6. All of the following are examples of sensory system symptoms except:
 A. Trouble integrating information from the visual world into motor output
 B. **Chronic constipation**
 C. Low tolerance for loud sounds
 D. Avoidance of movement
 E. Refusal to eat crunchy or hard foods

5. Pre= 76% Post= 85% Increase: 9%
 6. Pre= 50% Post= 82% Increase: 32%

**Guiding Principle
 Open Learning System**

Never a failure.
 Always a lesson.

© Pamela F. Fiesch

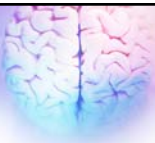
What do you need to know before we you can learn more today?



**NEED
TO
KNOW**

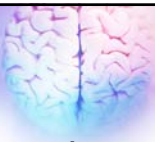
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Confidentiality Pledge



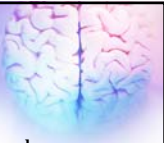
- We are honored to share a family's struggles
- We respect the journey
- We commit to keeping privacy to this day, in this room, for these families
- We use the descriptive terms such as "the baby in the Blue Zone and the toddler in the Red Zone" to keep a collegial conversation alive

Intervention Guiding Principles
Step #1, Bottom-up



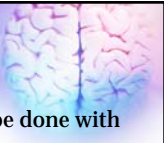
- With an infant you don't have an option to use top-down strategies; this becomes more deceptive with older children who have language skills
- When working with Step #1 to get to Green, always begin with bottom-up strategies - use your child's and your own individualized *sensory preferences* for stress recovery back to green
- Bottom-up strategies experiment with giving the right "dose" of a sensory preference in terms of duration, intensity, and rhythm (frequency)

Intervention Guiding Principles
Step #1, Bottom-up



- Often, talking during a stress response (a top-down strategy) only makes it “worse” increasing the intensity and the duration of the stress response
- Bottom-up strategies use your child’s and your own individualized *sensory preferences* for stress recovery back to green
- Bottom-up strategies experiment with giving the right “dose” of a sensory preference in terms of duration, intensity, and frequency

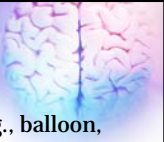
Sensory motor strategies



Acute: simple and immediate that can be done with very little effort

- Body squeeze (wrap arms around, squeeze) with or without...rocking (turtle)
- Rocking
- Heavy or weighted blanket placed over body
- Music ear buds; have favorite song ready to go
- Vial of favorite aromatherapy oil in purse/pocket
- Favorite chewing gum in pocket
- Walking

Sensory motor strategies



Daily rhythms: am, afternoon, pm

- Deep breathing throughout the day (e.g., balloon, pretzel, star)
- Calm music playing during transitions; music signals trans
- Certain routines during recess that embody sensory preferences (e.g., swings, monkey bars, sand box)
- Riding bike after school
- Warm bath; warm milk
- Being read to at night while tucked in
- Hugging lovey – e.g., lavender scented plush toy that can be heated up and hugged

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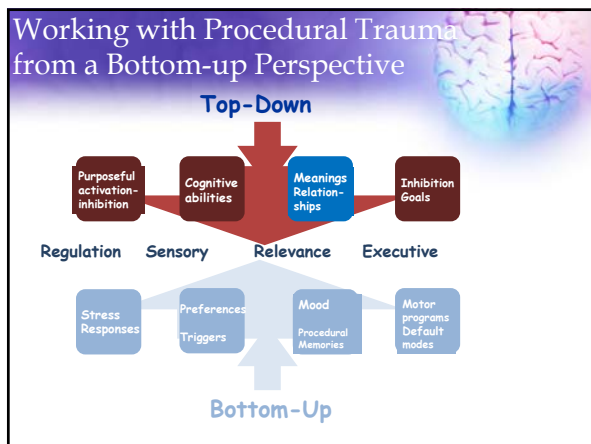
Sensory motor strategies

Weekly rhythms:

- Yoga/meditation class
- Sensorimotor therapy with an OT
- Playing a team sport
- Working out (e.g., swimming, gym)
- Neurofeedback twice a week
- Cranial-sacral therapy
- Massage
- Drumming
- Dancing

Matching or Countering the Sensory Modality

<p>Low Intensity, Slow Rhythm</p> <p><i>Match</i></p> <p>Lower lights and sounds Lower tone of voice Slow down vocal rhythm Slow down facial expression Slow movement</p> <p><i>Counter</i></p> <p>Increase lights and sounds High pitched tone of voice Rapid vocal rhythms Bright facial expressions Fast movement</p>	<p>High Intensity, Fast Rhythm</p> <p><i>Match</i></p> <p>Increase lights and sounds High pitched tone of voice Rapid vocal rhythms Bright facial expressions Fast movement</p> <p><i>Counter</i></p> <p>Lower lights and sounds Lower tone of voice Slow down vocal rhythm Slow down facial expression Slow movement</p>
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The Power of Procedural Play

EBT's with Top Down Capacities to
 Work Through Trauma

Trauma-focused CBT – the child's narrative is the goal
Child Parent Psychotherapy – the use of symbolic play
 and the narrative linked between the past and present is
 the goal

- Not all narratives are verbal!!!
- Some are Procedural Enactments!
- The case Cathy Pope and team will present to you
 next month will also show you this same
 phenomenon

The Emotional Story

Please use five words or phrases that
 describe your relationship with your child

- What's your history of being able to calm
 and comfort your child?
- Has anything happened that shouldn't
 have happened or any hard thing that has
 happened – small or large – that your
 child has gone through that would affect
 his/her behavior?
- What gives you the most joy in being
 with your child?
- Has anything scary or violent
 happened?
- Immigration history?
- Loss, sudden or expected?
- Experiences as a parent where you have
 felt empowered and competent?

- Any changes (e.g., new job, new baby, new
 home)?
- History of mental illness in the family on
 either side?
- Any history of substance within or close to
 the family? (linked with Regulation/Early
 story)
- Experiences you have had as a parent being
 in a position where you have been excluded
 or treated poorly?

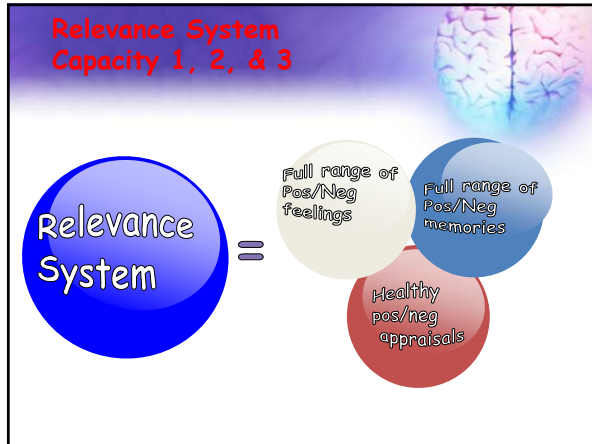
What's your greatest fear in being (name of
 child) parent?

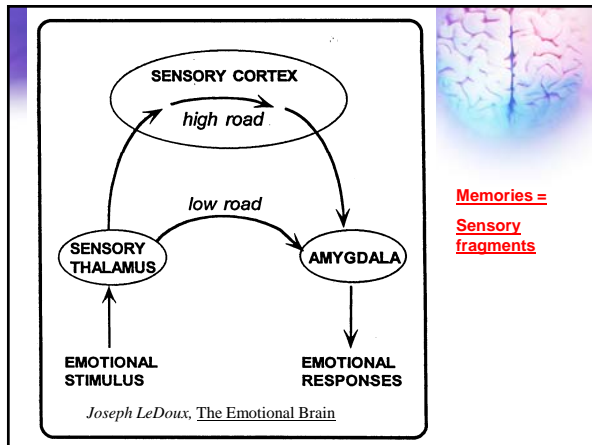
What's been a rewarding experience for you
 in being a parent?

Step Three Materials
The Four Stories

<p>History and Extended Needs Assessment</p> <ul style="list-style-type: none"> • Emotional Story <ul style="list-style-type: none"> – Combined history of ACE's – Trauma & Mental Health History 	<p>Current Capacities for Each Brain System</p> <ul style="list-style-type: none"> • Relevance System <ul style="list-style-type: none"> – Three functional capacities, linked with Step 1; Step 2, Levels 3 & 6 – Full range of positive/negative feelings or weighted towards too much positive/too much negative? – Cascade effect
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Colored Zones are the background to Emotional Regulation

Possible Regulation and Stress Response Correlates of Interpersonal Modes Across the Lifecycle

Interpersonal Mode	Self-Regulation	Self-Regulation	Self-Regulation	Self-Regulation
Secure	Secure attachment, high self-regulation, low stress response	Secure attachment, high self-regulation, low stress response	Secure attachment, high self-regulation, low stress response	Secure attachment, high self-regulation, low stress response
Insecure	Insecure attachment, low self-regulation, high stress response	Insecure attachment, low self-regulation, high stress response	Insecure attachment, low self-regulation, high stress response	Insecure attachment, low self-regulation, high stress response
Disorganized	Disorganized attachment, low self-regulation, high stress response	Disorganized attachment, low self-regulation, high stress response	Disorganized attachment, low self-regulation, high stress response	Disorganized attachment, low self-regulation, high stress response

Emotions Color Wheel

Relevance System Capacity Two...

Range of memories = Positive valence, Negative valence, Modulated to context

Relevance System Capacity Three...

Accurate meanings = Positive valence, Negative valence, For self & others

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NRF Guiding Play Principles

- Always work with developmental age, not the chronological age
- When moving up the developmental ladder, consider procedural enactments as part of the emergence of emotional memories that are not always symbolized through symbolic play or with a verbal narrative
- **“Pretend” play can hold procedural memories that are not yet verbalized into a “verbal narrative” yet embody a “body narrative”**

NRF Guiding Play Principles

- Procedural memories that are not yet verbalized can help us understand traumatic memories that are lodged in the body
- These are now **“sensory fragments” (this is what memories are)** lodged in the “relevance” system that shape our meaning-making experiences
- **While useful, one does not always have to “know” the history of the child to work with the child. “The brain is a historical organ.” (B Perry)**

NRF Guiding Play Principles

- While following the child’s lead and their interests, in general, work with expanding their emotional range from the constrictions they have
- **Use the color wheel to see how expansive or how constricted their emotional range is, linked with colored zones**
- **With trauma link the aggressor with the victim (old) with a protector (new)**
- **Many times young children take on the role of the aggressor (red zone) as a “one size fits all”**

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Social Worker Referral

- SW had been in my Specialized Foster Care year long course from 2002 to 2003 (Barbara Stroud was in this class!)
- The non-linear aspects of community systems change – chaos theory at it's best!

Case Study Timeline: Kai

```

    graph TD
      A["Removed from home (lessness)  
At 15 months | Severe abuse & Neglect"] --> B["Placed in foster home  
From 15 to 34 months | Custodial care"]
      B --> C["Placed in foster-adopt home  
At 34 months | Recovery Resources Begin"]
      C --> D["Period of Deterioration  
~37 to 38 months | Advent of Reunification Weekends"]
      D --> E["Adoption  
At 42 months | Treatment"]
  
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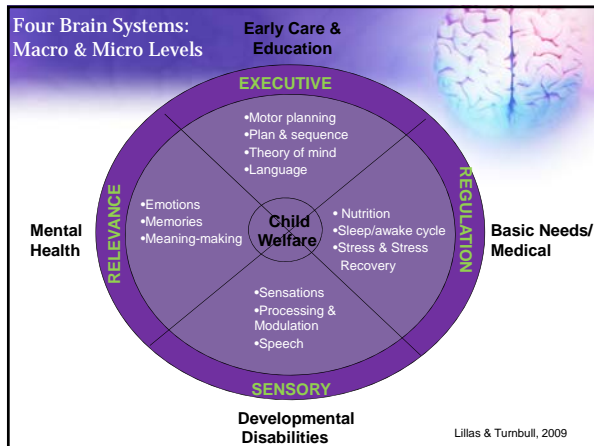
Adverse Childhood Experiences Scale

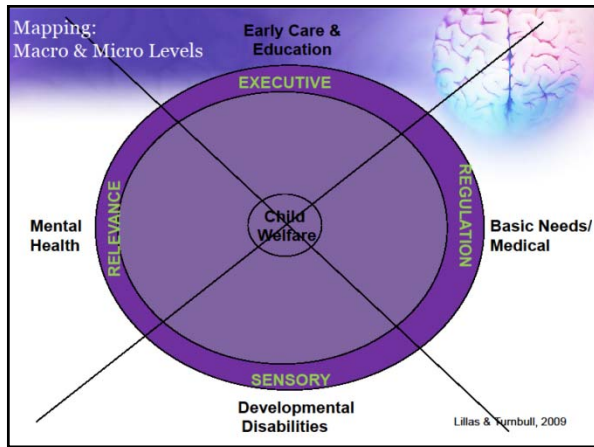
CA's ACE List

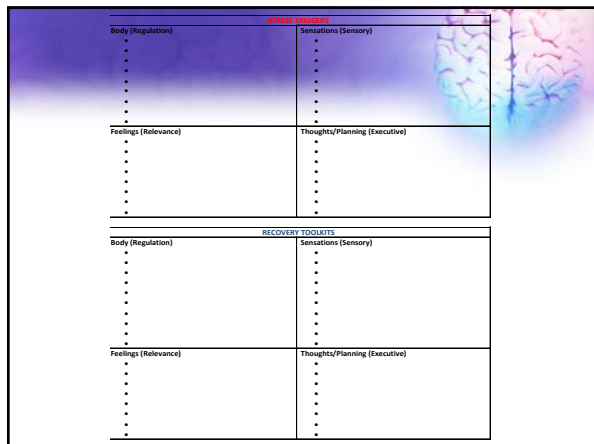
What we knew at the start...

1. Recurrent physical abuse
2. Recurrent emotional abuse
3. Contact sexual abuse
4. An alcohol and/or drug abuser in the household
5. An incarcerated household member
6. Someone who is chronically depressed, mentally ill, institutionalized, or suicidal
7. Violence between adults in the home
8. Parental separation or divorce
9. Emotional or physical neglect

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List of Symptoms & Dx

<p>Symptoms Group A</p> <p>BEHAVIOR IN FOSTER HOME</p> <ul style="list-style-type: none"> • Frequent crying & aggression (red zone) • Chronic diarrhea • Speaks one word • "Resistant" to parental boundaries • "Refusal" to toilet train • Disrupted sleep/awake cycles – falls asleep in the middle of the floor with no schedule • Wandering aimlessly in a daze (blue zone) 	<p>Diagnostic Categories</p> <p>Diagnosed from Regional Center:</p> <ul style="list-style-type: none"> • Dx with severe developmental & speech delays • Dx with Reactive Attachment Disorder • Dx with Intellectual Disability (previously referred to as Mental Retardation)
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List of Symptoms & Dx

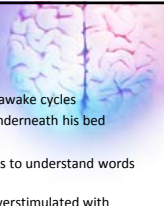
<p>Symptoms Group B</p> <p>FIRST MONTH OF BEING IN FOST-ADOPT HOME</p> <ul style="list-style-type: none"> • Hyperexcited with toys; aimlessly running from toy to toy without purposeful behavioral initiation • No registration of pain • Hoarding food underneath his bed • Appears easily overstimulated with people and toys • Screaming when limits are set • Babbling; appears to understand words spoken to him • Hyperexcited with "company"; running around to everyone frenetically • Unable to fall asleep on his own, staring off into space (blue zone) for long periods of time 	<p>Diagnostic Categories</p> <p>Diagnosed from Regional Center:</p> <ul style="list-style-type: none"> • Dx with severe developmental & speech delays • Dx with Reactive Attachment Disorder • Dx with Intellectual Disability (previously referred to as Mental Retardation)
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"Macro" Level Overview- CASE STUDY (KAI)
 Fost-adopt parents informed of Kai's Profile

<ul style="list-style-type: none"> • Regulation: Bodily/Medical Needs • Sensory: Developmental Needs • Relevance: Mental Health Needs • Executive: Learning & Educational Needs 	<ul style="list-style-type: none"> • "Refusal" to toilet train • Chronic diarrhea • Red and blue zones • Dx with severe developmental & speech delays • Frequent crying & aggression • "Resistant" to parental boundaries • Dx with Reactive Attachment Disorder • Dx with Intellectual Disability (previously referred to as Mental Retardation)
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"Micro" Level Overview- CASE STUDY (KAI)
 Observations When He Arrives to Fost-Adopt Home




<ul style="list-style-type: none"> • Regulation: Balance of 24-hour Sleep/Awake Arousal 	<ul style="list-style-type: none"> • Disrupted sleep/awake cycles • Hoarding food underneath his bed
<ul style="list-style-type: none"> • Sensory: Balance of Processing & Modulation of Sensations 	<ul style="list-style-type: none"> • Babbling; appears to understand words spoken to him • Appears easily overstimulated with people and toys • No registration of pain
<ul style="list-style-type: none"> • Relevance: Balance of pos/neg Emotions, Memories, & Meanings 	<ul style="list-style-type: none"> • Hyperexcited with "company"; running around to everyone frenetically • Screaming when limits are set
<ul style="list-style-type: none"> • Executive: Balance of initiating and sustaining thoughts, behaviors, & actions 	<ul style="list-style-type: none"> • Hyperexcited with toys; aimlessly running from toy to toy without purposeful behavioral initiation

Cultural Awareness Similarities & Differences



Similarities	Differences
<ul style="list-style-type: none"> • All sets of parents and Tx are Caucasian • Tx has experience with "violent" aggressive behavior with her boy Twin A 	<ul style="list-style-type: none"> • Referring SW on the case is African-American • Disagreements on the meaning of his behavior • Disagreements re: Dx • Fost-adopt & Tx do not have hx of being exposed to DV

Power differentials



- Socio-economic class differences
- Educational differences
- Age differences, fost-adopt parents are young
- Fost-adopt parents feel marginalized by institutions of DCFS/RC

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Reflection: Becoming Awake and Aware

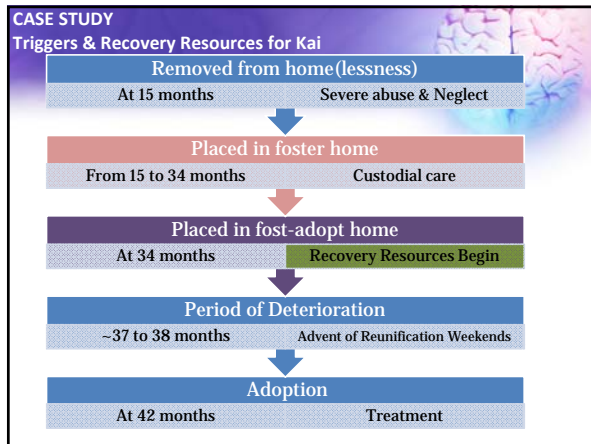
- In navigating of our clinical worlds and our relationships we usually are doing one of two things:
 - We are trying to repeat what was wonderful and effective in our familial cultural background
 - We are trying to repair or rectify what was not effective in our familial cultural background
- What is the challenge?
 - Identifying our tendencies to repeat what didn't work because it feels natural and familiar, not because it was effective!

Parallel Processes

<p>Comfortable</p> <ul style="list-style-type: none"> • Understand being a parent who does not feel validated – using my heart! 	<p>Uncomfortable</p> <ul style="list-style-type: none"> • Do not want to engage in splitting of providers, staying neutral at the front-end – keeping a cool head!
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Heart, Hand, and Head Patterns				
	Under Coordination		Under Stress	
Heart 1s	Warm Empathic Connect Repair	Functional helper Share info. Make contact Cross-sector communication	Overly accommodating Overly controlling Anxious to fix things	Dysfunctional rescuing
Hand 2s	Assertive Directive, action oriented	Take the lead Confront Stand up Notice and share differences	Overly demanding Hostile attack	Blaming the victim Blaming the system
Head 3s	Neutral Reflective Problem-solve <small>Dr. Connie Lillas</small>	Take responsibility Learn, ask, & notice the impact <small>Dr. Valerie Batts</small>	Overly detached Overly dismissive Passive-aggressive anger Denial <small>Dr. Connie Lillas</small>	Passive avoidance Antagonistic avoidance Denial of differences across domains <small>Dr. Valerie Batts</small>

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Regulation System
 -Triggers

Behaviors Observed	Possible Underlying Explanations
Chronic awake dysregulation	<ul style="list-style-type: none"> No procedural memories of comfort or getting to green zone
Chronic sleep dysregulation	<ul style="list-style-type: none"> No procedural memories of co-regulation for sleep
Hoarding food	<ul style="list-style-type: none"> Procedural memories of neglect, hunger

Sensory System
 -Triggers (with some resilience)

Behaviors Observed	Possible Underlying Explanations
Appears easily overstimulated with people and toys	<ul style="list-style-type: none"> Possibly gone from an understimulating – custodial care environment (last foster home) to now an overstimulating environment (too many toys, too many people) Modulation difficulties
Babbling; appears to understand words spoken to him	<ul style="list-style-type: none"> Speech delay but beginning to vocalize at 6 to 9 month level Appears to have receptive language skills and to process information

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Relevance System
 -Triggers

Behaviors Observed	Possible Underlying Explanations
Hyperexcited with "company"; running around to everyone frenetically	<ul style="list-style-type: none"> Poor or no procedural memories of connecting to safe person(s) for source of comfort & joy
Screaming when limits are set	<ul style="list-style-type: none"> Both hyperexcitement and rage aspect of disinhibited type of RAD

Executive System
 -Triggers

Behaviors Observed	Possible Underlying Explanations
Hyperexcited with toys; aimlessly running from toy to toy without purposeful behavioral initiation	<ul style="list-style-type: none"> Poor or no procedural memories of sequence & structure Poor or no procedural memories of engagement

Recovery Resources Used
 First 4 to 6 Weeks

Column A	Column B
<ul style="list-style-type: none"> House "rules" – only health & safety Immediately stopped having people over Sitting next to Kai until he falls asleep "Toddler-proofed" the home Post-adopt takes two weeks off from work to be home 24/7 Speak in shorter sentences; less words, more gestures Healthy snacks in bottom shelf, 24/7 access Playing outside with sensory-motor play 	<ul style="list-style-type: none"> Visual sequence for day set up with Velcro strip Superdawg sleeps with Kai Toys in rotating boxes Food allergies – help with diet Kai has receptive skills & understands when spoken to House "rules" are non-negotiable items w/visual cues Calming & regular rhythms set up

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Regulation System
 -Recovery Resources

<u>Behaviors Observed</u>	<u>Resources Attempted / Implemented</u>
Chronic awake dysregulation	<ul style="list-style-type: none"> Searching for ways to soothe and calm
Chronic sleep dysregulation	<ul style="list-style-type: none"> Sitting next to Kai at night in his bedroom until he falls asleep
Hoarding food	<ul style="list-style-type: none"> Placing healthy food snacks on bottom shelf in kitchen that Kai can go to and reach on his own 24/7
Chronic diarrhea	<ul style="list-style-type: none"> Suspected food allergies

Sensory System
 -Recovery Resources

<u>Behaviors Observed</u>	<u>Resources Attempted / Implemented</u>
Appears easily overstimulated with people and toys	<ul style="list-style-type: none"> Fost-adopt Dad took 2 weeks off from work to be home 24/7 Immediately stopped having people over Simplified toys into rotating boxes, one per week Superdawg was recognized as comforting, supporting green zone, and facilitating sleep; allowed to sleep with him
Babbling; appears to understand words spoken to him	<ul style="list-style-type: none"> Parents speaking in shorter sentences With less stimulation, talking begins to him

Relevance System
 -Recovery Resources

<u>Behaviors Observed</u>	<u>Resources Attempted / Implemented</u>
Hyperexcited with "company"; running around to everyone frenetically	<ul style="list-style-type: none"> Playing with limited toys with intent to look at each other's faces and to create joy Playing outside naturally created more opportunities for shared joy; sensory-motor play on slide and swing created more opportunities for facial contact (earlier relational milestones)
Screaming when limits are set	<ul style="list-style-type: none"> "Toddler-proofed" the house For every "no" there was at least one "yes" Non-negotiable #1s were narrowed to safety and health needs

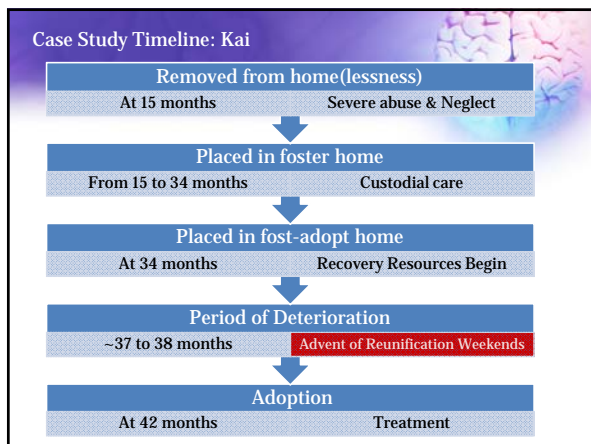
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Executive System
 -Recovery Resources

Behaviors Observed	Resources Attempted / Implemented
Hyper-excited with toys; aimlessly running from toy to toy without purposeful behavioral initiation	<ul style="list-style-type: none"> Visual sequence & structure of the day set up with Velcro strip and pictures By limiting contact to foster-adopt parents, rhythms were set up that included a calming & predictable schedule House "rules" of #1s are in visual view (brushing teeth, holding hand when crossing the street, etc.) Transitions prepared for with visual and auditory prompts; not done abruptly unless necessary

"Micro" Level Overview
 Within Two to Six Weeks In Foster-Adopt Home

<ul style="list-style-type: none"> Regulation: Balance of 24-hour Sleep/Awake Arousal Sensory: Balance of Processing & Modulating Sensations Relevance: Balance of pos/neg Valenced Emotions, Memories, & Meanings Executive: Balance of initiating and sustaining thoughts, behaviors, & actions 	<ul style="list-style-type: none"> Red & blue zone behaviors decreased Green zone improved Food allergies noted – chronic diarrhea stopped Sleeping alone by end of month Within two weeks began to talk in one and two word sentences Within one month talking non-stop with articulation problems Sharing joy with foster-adopt parents More cooperative Showing appropriate stranger anxiety around strangers Obvious Kai does not have intellectual disability Responding to predictable schedule
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List of Symptoms & Dx

Symptoms Group C	Diagnostic Categories
<p>RETURNS FROM BIRTH MOTHER WITH:</p> <ul style="list-style-type: none"> Speech returns back to primarily babbling Begins to pull out his own eyelashes Aggression returns, accompanied with cussing and use of swear words <p>By end of third weekend visit:</p> <ul style="list-style-type: none"> Begins to cry and protest on the way to the train Begins to pull out his fost-adopt mother's hair and doll hair Hysterically screams when he's not in control Inconsolable at night Diarrhea returns 	<p>Diagnosed from Regional Center:</p> <ul style="list-style-type: none"> Dx with severe developmental & speech delays Dx with Reactive Attachment Disorder Dx with Intellectual Disability (previously referred to as Mental Retardation)

"Micro" Level Overview
After 3 months, Reunification Visits Began/Birth Mom

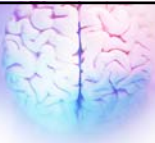
<ul style="list-style-type: none"> Regulation: Balance of 24-hour Sleep/Awake Arousal 	<ul style="list-style-type: none"> Red zone aggression returned and increased Blue zone starrng off into space when awake for long periods Inconsolable and crying at night Diarrhea returned after bio visits
<ul style="list-style-type: none"> Sensory: Balance of Processing & Modulation of Sensations 	<ul style="list-style-type: none"> With aggression, cussing and swearing Speech returns back to babbling
<ul style="list-style-type: none"> Relevance: Balance of pos/neg Emotions, Memories, & Meanings 	<ul style="list-style-type: none"> Begins to pull out his own eyelashes With reunification visits continuing, he shows distress on the way to the train, asking not to leave
<ul style="list-style-type: none"> Executive: Balance of initiating and sustaining thoughts, behaviors, & actions 	<ul style="list-style-type: none"> Begins to pull out his F mom's hair and hair off of dolls Hysterically screams when he's not in control

"Micro" Level Overview- CASE STUDY (KAI)
Observations When He Arrives to Post-Adopt Home

<ul style="list-style-type: none"> Regulation: Balance of 24-hour Sleep/Awake Arousal 	<ul style="list-style-type: none"> Disrupted sleep/awake cycles Hoarding food underneath his bed
<ul style="list-style-type: none"> Sensory: Balance of Processing & Modulation of Sensations 	<ul style="list-style-type: none"> Babbling; appears to understand words spoken to him Appears easily overstimulated with people and toys No registration of pain
<ul style="list-style-type: none"> Relevance: Balance of pos/neg Emotions, Memories, & Meanings 	<ul style="list-style-type: none"> Hyperexcited with "company"; running around to everyone frenetically Screaming when limits are set
<ul style="list-style-type: none"> Executive: Balance of initiating and sustaining thoughts, behaviors, & actions 	<ul style="list-style-type: none"> Hyperexcited with toys; aimlessly running from toy to toy without purposeful behavioral initiation

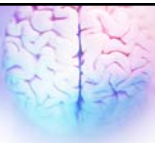
NRF Model Case:
 The Power of Procedural Play
 Using the NRF in Clinical Practice

Cultural Awareness
Similarities & Differences



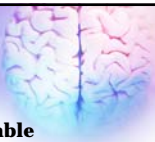
<p>Similarities</p> <ul style="list-style-type: none"> • All parents and Tx are Caucasian • Tx has experience with "violent" aggressive behavior with her boy Twin A 	<p>Differences</p> <ul style="list-style-type: none"> • Referring SW on the case is African-American • Disagreements on the meaning of his behavior • Disagreements re: Dx • Fost-adopt & Tx do not have hx of being exposed to DV
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Power differentials



- Socio-economic class differences
- Age differences, fost-adopt parents young
- Educational differences
- Fost-adopt parents feel marginalized by institutions of DCFS/RC

Parallel Processes



<p>Comfortable</p> <ul style="list-style-type: none"> • Understand being a parent who does not feel validated – using my heart! 	<p>Uncomfortable</p> <ul style="list-style-type: none"> • Do not want to engage in splitting of providers, staying neutral at the front end – keeping a cool head! • Very uncomfortable now with the progress and regress Kai is showing us • His symptoms turn this into a 911 context for me • Now, the Hand comes out to have action & to speak up!
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NRF Model Case:
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Heart, Hand, and Head Patterns				
	Under Coordination		Under Stress	
Heart 1s	Warm Empathic Connect Repair	Functional helper Share info. Make contact Cross-sector communication	Overly accommodating Overly controlling Anxious to fix things	Dysfunctional rescuing
Hand 2s	Assertive Directive, action oriented	Take the lead Confront Stand up Notice and share differences	Overly demanding Hostile attack	Blaming the victim Blaming the system
Head 3s	Neutral Reflective Problem-solve <small>Dr. Connie Lillas</small>	Take responsibility Learn, ask, & notice the impact <small>Dr. Valerie Batts</small>	Overly detached Overly dismissive Passive-aggressive anger Denial <small>Dr. Connie Lillas</small>	Passive avoidance Antagonistic avoidance Denial of differences across domains <small>Dr. Valerie Batts</small>

NRF Guiding Principles

When there is a loss of health or developmental gains...

- Whenever possible, recommend a return to the previous conditions of that supported baseline health
- Whatever relationships were promoting baseline health need to be honored
- A collision of safety and threat
- One has to consider that procedural memories are being triggered by the forced reunions with an abusive, neglectful, or terrorizing parent

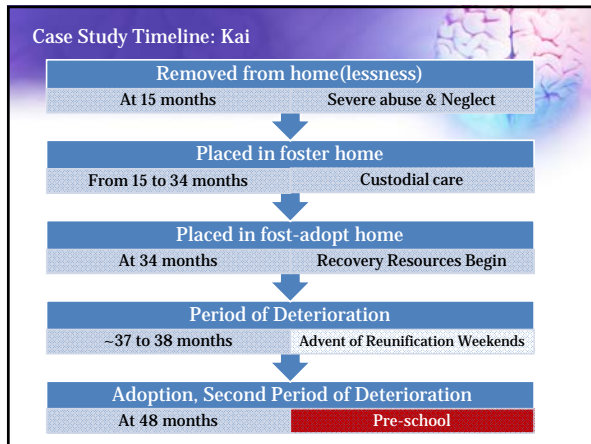
Multiple Dimensions of Trauma

Play Themes of the Relevance System

<p>Constricted Play Themes</p> <ul style="list-style-type: none"> • No affect • Only brief positive affect • Predominance of negative range, with no positive affect • Predominance of positive range, with no negative affect 	<p>Extreme Play Themes</p> <ul style="list-style-type: none"> • Repeated aggression • Destructive actions to vulnerable other(s) • Repeated victimization scenarios • Destructive behaviors (e.g., head-banging, self-biting, biting others) • Repeated themes of suspicion and fear
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Symptoms Group D

- Even though liking his teachers, began biting his teachers and friends
- Waking up screaming in pain; rubbing his legs
- Nightmare of "old daddy" finding him and biting his arm off
- Lots of sensory stimulation at school, 40 students
- Loss of bowel/bladder control
- Worried his "old daddy" would show up at home or school to steal him
- Developmental school with lots of free choice, lots of stations; open spaces for going inside and outside the classroom

"Micro" Level Overview

Began Pre-school and 2nd Period of Deterioration

<ul style="list-style-type: none"> • <i>Regulation:</i> Balance of 24-hour Sleep/Awake Arousal 	<ul style="list-style-type: none"> • Nightmare of "old daddy" finding him and biting his arm off • Loss of bowel/bladder control
<ul style="list-style-type: none"> • <i>Sensory:</i> Balance of Processing & Modulation of Sensations 	<ul style="list-style-type: none"> • Waking up screaming in pain; rubbing his legs • Lots of sensory stimulation at school, 40 students
<ul style="list-style-type: none"> • <i>Relevance:</i> Balance of pos/neg Emotions, Memories, & Meanings 	<ul style="list-style-type: none"> • Even though liking his teachers, began biting his teachers and friends • Worried his "old daddy" would show up at home or school to steal him • Considered all of these behaviors as part of procedural memories
<ul style="list-style-type: none"> • <i>Executive:</i> Balance of initiating and sustaining thoughts, behaviors, & actions 	<ul style="list-style-type: none"> • Developmental school with lots of free choice, lots of stations

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 Using the NRF in Clinical Practice

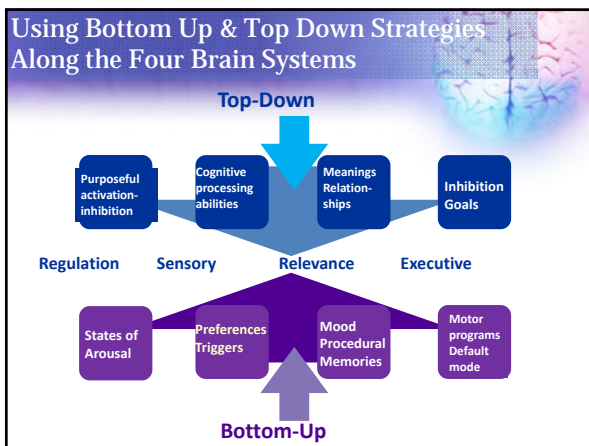
NRF Guiding Principles

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- **Whenever possible, recommend a return to the previous conditions of that supported baseline health**
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- One has to consider that procedural memories are being triggered by the forced reunions with an abusive, neglectful, or terrorizing parent

Review: The Use of the Self

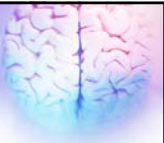
- **Heart:**
 - Empathic towards fost-adopt parent's struggle and feeling marginalized
- **Hand:**
 - Limits set with Kai with his torturous behaviors
 - Action/Advocacy, asking for limits from the Courts
 - Asked for limits with parents
- **Head:**
 - At front-end staying neutral and pacing to find out who Kai was as we got green and stabilized



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Begins with procedurally enacting...

- The role of the aggressor



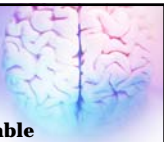
Cultural Awareness Similarities & Differences

<p>Similarities</p> <ul style="list-style-type: none"> • All parents and Tx are Caucasian • Tx has experience with "violent" aggressive behavior with her boy Twin A 	<p>Differences</p> <ul style="list-style-type: none"> • Referring SW on the case is African-American • Disagreements on the meaning of his behavior • Disagreements re: Dx • Fost-adopt & Tx do not have hx of being exposed to DV • Now: Value differences in how to view "protection" and range of emotions between Rx/Adpt Mom
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Parallel Processes


<p>Comfortable</p> <ul style="list-style-type: none"> • Understand being a parent who does not feel validated – using my heart! 	<p>Uncomfortable</p> <ul style="list-style-type: none"> — Do not want to engage in splitting of providers, staying neutral at the front end — keeping a cool head! — Very uncomfortable now with the progress and regress Kai is showing us — His symptoms turn this into a 911 context for me — Now, the Hand comes out to have action & to speak up! • I see the process of K's using aggression again and have a sinking feeling in my stomach, that he has no other way to protect himself but through aggression... • Having to feel my way through this with my visceral self • Sensitive to not shame yet shift!
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Beginning to procedurally enact.....



- The role of the victim...

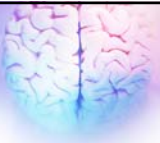
Beginning to procedurally enact.....



- Spontaneously, the role of the protector...

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Community Projects & Special Interests



1. Region wide Intake design and planning
2. Endorsement Process emphasis (portfolio workshops?)
3. Implementing Reflective Practice
 - More people trained to do it
 - Increase use of RP in agencies by including RP in all training programs
 - Increase use of RPF using NRF
4. NRF Community Training Consortium
 - In-service in own agency
 - Community training
 - Public Health/Home Visitors
 - Education – EHS/EI systems
 - Child Welfare
 - CVRC
 - Fundamentals of 4C's NRF
5. Cultural Barriers (of Shame)
 - Shame of men in practice and participating within families
 - Shaming of Mental health needs
 - Denial of Trauma
 - Simple solutions for complex problems
6. Continuing Collaborative Systems

*Other?



Thank You!
