

### **Dynamics of Multidisciplinary Team Treatment Planning for a Child with Reactive Attachment Disorder: From Despair to Hope in an Interagency Team Process**

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#### **Introduction**

This paper considers the experience of a multidisciplinary team assembled to address treatment issues regarding a child with a diagnosis exemplary of the complexity of modern-day child psychiatric diagnostic and treatment approaches: Reactive Attachment Disorder.

The literature on treatment approaches to children with serious emotional and behavioral disturbances cites the increasing complexity of treatment teams, and therefore the need for wisdom and practical skills in promoting the efficacy of those teams and avoiding fragmentation of care (Rosenheck, 1988). General systems theory has lent some very useful concepts to our understanding of the dynamics of interpersonal team functioning. Most notably, we should think of treatment teams as *antireductionistic*, *nonsummative*, and *constructivist*. That is, an effective treatment team is an organic unit that cannot be reduced to a sum of its parts (i.e., participants), and creates a product (an effective treatment) that requires the synthesizing effort of all of its participants. Further, general systems theory alerts us that the *homeostasis* of a treatment team depends on a dynamic

balance between *morphogenetic* and *morphostatic* forces, those promoting flexibility and change vs. those promoting stability and constancy (Sadock & Sadock, 2000).

Several authors have contributed keen observations and caveats regarding multidisciplinary mental health treatment team functioning. Madge and Khair have noted several factors prevalent in successful teams, including: *enthusiasm, dedication, team philosophy, leadership, dynamics, communication, workload, and valuation of each member's contribution*. They also note the following prevalent hazards to effective team function: uncertainty regarding team role and function, overly burdensome caseloads, poor coordination and uneven work distribution (Madge & Khair, 2000). Butterill, O'Hanlon and Book note that common mental health treatment team problems also include *poorly defined accountability* and *boundary violations* (Butterill, O'Hanlon, & Book, 1992). They recommend teaching of organizational theory, open discussion of contentious issues and reinforcement of boundaries. Perl notes that the ability of a therapist [treatment team] "to understand and accept conflicting perspectives with respect to a given patient, can help that patient begin to tolerate and integrate his

or her own ambivalent feelings" (Perl, 1997). DeCivita and Dobkin note three treatment team factors that affect a pediatric patient's adherence to the treatment plan: *multidimensionality*, to support the complexity and interrelatedness of treatment components; an intact *triad* of relationships, including caregiver-child, caregiver-medical team and child-medical team components; and a *dynamic* nature in the team, adapting to ongoing changes in the child's development and in the context in which he lives (DeCivita & Dobkin, 2004).

Some authors use the word "teamness" as an overarching principle of effective multidisciplinary mental health treatment team functioning. Iedema, Meyerkort and White note that "the organizational-managerial point of gravity of most clinical work lies with those who do the work" (Iedema, Meyerkort, & White, 2005). They observe that *flexible, self-organizing* teams are in the best position to handle the increasing fragmentation and complexity of health services. Yank, et. al. define "teamness" as "the key set of intangible phenomena that allow a team to function synergistically as more than a sum of its parts, and with a sense of team identity." They note that the "subjective experiences and emotional reactions of the leader and team members can be used to promote improved task performance and clinical care" (Yank, et al., 1979).

Unfortunately, a circumstance noted in 1979 by Reinharz and Lowental continues to plague mental health treatment teams today; namely, that in community mental health heterogeneous groups of professionals infrequently achieve "group cohesiveness or a sense of community" (Reinharz & Lowental, 1979). Certainly, community mental health practitioners can justifiably point to funding and time

limitations as limiting their ability to bond as a cohesive team. But a number of researchers point also to other contributing systemic problems. Boaden and Leaviss note that the organization and management of delivery of healthcare via multidisciplinary teams has not been well taught traditionally in professional training. Specifically, while some attention is paid to team dynamics, the types of teams and the context in which they operate are neglected (Broaden & Leaviss, 2000). Rodenhauser finds that in the training of psychiatrists, treatment team dynamics and their leadership role are seriously underemphasized (Rodenhauser, 1996). At the same time Shabbir and Banerjee note that the opportunities for training doctors for team leadership roles are diminishing (Shabbir & Banerjee, 2004).

Complex clinical situations are proportionately more likely to expose the above-mentioned weaknesses in multidisciplinary treatment team functioning. However, they also provide the opportunity for more innovative team functioning, and for advancing our knowledge base regarding optimum functioning of mental healthcare teams in human systems of ever-increasing complexity.

## Case Presentation

Kasey (a pseudonym), a twelve-year-old adopted girl with the diagnosis subsequent to adoption of Reactive Attachment Disorder (RAD), was currently in treatment at a Residential Treatment Facility (RTF) in Pennsylvania. Her biological family history was marked by intergenerational traumatic parent-child relationships. Her biological mother was abandoned by her own mother at 12 months of age, was adopted, and subsequently sexually abused by her adoptive father (which abuse was denied by her adoptive

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mother). She would ultimately abandon her own children—Kasey and her younger sister—in a car, leading to a series of placements within and without the extended biological family, and ultimately to their adoption by Mr. and Mrs. G, a couple with three biological children, all boys. Kasey was found to have been sexually abused during at least one of her pre-adoptive placements, required surgery as a consequence of the abuse, and in the aftermath had begun to show sexually provocative behavior.

In her adoptive home Kasey soon began to show the full range of bizarre and disruptive behaviors typical of children with a history of grossly disturbed attachments and trauma. Initially her animosity was directed primarily toward her adoptive mother, who soon began to recognize Kasey's attempts to divide the rest of the family against her. Her parents promptly sought evaluation and treatment, and Kasey was diagnosed with Reactive Attachment Disorder. As Kasey did not improve after 1½ years of outpatient treatment, including "holding therapy" (entailing her being physically held by the therapist and/or a parent during therapy sessions,) her parents explored several other avenues of help including their county Mental Health/Mental Retardation unit.

Unfortunately, typical of families living with a child with Reactive Attachment Disorder, Kasey's parents began to feel increasingly misunderstood and disenfranchised. Their degree of frustration and fear in daily life with Kasey was not immediately apparent in her typically brief initial evaluations. Her parents began to feel blamed, judged and chastised. Eventually, through personal diligence, Kasey's parents came into contact with the care manager of her behavioral health managed care organization for considera-

tion of more intensive treatment. (In the Commonwealth of Pennsylvania, public mental healthcare is administered by contracted managed care organizations [MCO's], whose care management is monitored by administrative staff and mental health professionals at the county, regional and state levels. Those representatives are available to assist in resolving problems in the clinical care of children receiving public mental health funding.) While Mr. and Mrs. G felt that Kasey needed out-of-state residential treatment at a facility specializing in treatment of children with Reactive Attachment Disorder, they eventually accepted the care manager's recommendation for placement in an in-state residential facility known for its staff's special interest and training in treating children with attachment pathology. Even this in-state facility was over 200 miles from the G home, making regular family involvement in Kasey's treatment problematic.

After an extended "honeymoon" period in the RTF with minimal behavioral issues being exhibited, as is typical of youth with RAD, Kasey began to show many of the disturbed relationship behaviors reminiscent of her behavior at home. The treatment team at the RTF became increasingly frustrated by the relative unavailability of the family for family therapy, and Kasey's parents began to feel accused of not making enough effort to travel regularly to be involved in her care. (They recall having given notice at the outset of Kasey's residential treatment that the demands of family, home and work would make their regular attendance at family sessions difficult at such great distance.) Ultimately Mr. and Mrs. G reached the conclusion that Kasey was not receiving adequate care in the RTF, and needed residential treatment in one of the out-of-state facilities known to specialize in treatment of children with

Reactive Attachment Disorder with staff available to serve as surrogate parents/attachment figures. Their impression was bolstered by the written opinion of one of Kasey's previous clinicians.

When the MCO indicated their support only for in-state placement for Kasey, Mrs. G then contacted by phone first the MCO care manager and staff, then the county oversight person (case manager at their local county Mental Health/Mental Retardation agency) and ultimately the children's program representative (BJ) at the regional Field Office of the state Office of Mental Health and Substance Abuse Services (OMHSAS). Thus, facilitating the resolution of this serious treatment impasse became the challenge of the latter person.

### Building an Effective Multidisciplinary/Multi-agency Team

Pennsylvania's Child and Adolescent Service System Program (CASSP) recommends the availability of a CASSP Coordinator or case manager to coordinate multi-agency service provision for children in the state who are seriously mentally ill. The process whereby this occurs is the Interagency Service Planning Team (ISPT) meeting, where the child's parents, the child if 14 years of age or older (or younger than 14 years if clinically appropriate and with agreement of parents), parent/child advocate(s) and selected support persons join together with evaluating clinicians, representatives of public agencies involved in the child's care (e.g. special education, juvenile probation, children and youth, MH/MR, MCO care management, etc.) and mental health services providers to develop a comprehensive and coordinated treatment plan specific to the child's needs. CASSP principles guide plan development, namely require that the

plan be *child-centered, family-focused, community-based, multi-system, and culturally competent*, and effective treatment must be provided in the *least restrictive/least intrusive manner possible*.

Mr. and Mrs. G did not readily embrace the idea of meeting with individuals they perceived as having preordained treatment decisions regarding their daughter. They felt that past efforts to coordinate effective treatment for their daughter resulted in failed treatments, and Mrs. G especially distrusted the sincerity of those with whom she had contact. Nevertheless, BJ endeavored to draw together Mr. and Mrs. G and their county and MCO staffs to establish an ISPT process for Kasey. She worked with Mrs. G to ensure that the ISPT be augmented with any additional personnel likely to help in resolving the impasse. She advised and supported Kasey's parents in inviting others, resulting in the addition to the team of two additional members: Kasey's adoption case manager, and a well-respected and articulate advocate for children's mental health services. Mrs. G also exercised her prerogative to exclude some professional staff from whom she felt particularly disconnected. BJ offered the family the opportunity for the participation of the child psychiatry consultant at her regional field office [JB] and a program representative of the "host home" service, to answer specific questions about that potential treatment setting.

The first ISPT meeting was facilitated by the family's advocate, who organized the team's thinking about Kasey's treatment needs around the question of what her parents hoped Kasey's life to be like in her early 20's. This meeting proved to be a "get acquainted" meeting, wherein Kasey's parents shared family pictures and a poignant review of their family's story with

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Kasey and her sister that served to meld the team into a shared empathic base and a resolve to creatively address the treatment impasse. Mother voiced her wish for a "second opinion" regarding the RTF's current assessment of Kasey's problems and their treatment approach. The meeting ended without a decision to pursue a second opinion, but instead with an agreement to invite additional RTF treatment staff to attend another ISPT meeting the following week.

The RTF staff, including the program director, the facility's psychiatrist and Kasey's therapist, eagerly agreed to be involved, and due to matters of distance joined the second and subsequent team meetings via speaker phone. BJ invited the therapy staff to summarize their current perspective on Kasey. They noted that she was tending to "act out" her feelings in therapy sessions and seek the approval of the therapist, and was doing well in school. But she had recently attempted to elope, and needed physical restraint on a separate occasion. The RTF team voiced great concern that the family was unavailable for family sessions, which they felt critical to Kasey's progression in treatment. The RTF team psychiatrist opined that Kasey was developing a positive attachment to her therapist, and recommended that discharge planning entail a therapeutic foster home for Kasey with "intensive family therapy" in the vicinity of the facility, so that the positive relationship with Kasey's therapist could be sustained. By the end of the meeting all involved parties seemed satisfied that the speaker phone hook-up with the RTF staff would work, even though later several ISPT members admitted that they found the lack of visual contact with members on the other end of a phone somewhat disconcerting. Kasey's parents commented that the RTF staff's comment about "inten-

sive family therapy" might be revealing resentment that the parents were not more regularly involved in Kasey's treatment at the RTF. They repeated their doubt that the RTF understood attachment-related pathology well enough to provide adequate care for Kasey. The meeting ended with an unresolved lingering tension between the parents and the RTF treatment team.

The third ISPT meeting occurred 5 weeks later, for which Kasey's mother also invited the leader of a support group she had been attending for parents of children with Reactive Attachment Disorder. The RTF staff reported that Kasey was talking increasingly in her therapy about past abuse, acknowledging increasing general mental confusion about things and discussing aggressive feelings toward staff, and engaging increasingly in art therapy. Her parents were doubtful about how much progress this represented, noting Kasey's tendency to dwell on acknowledged episodes of past abuse as a defense against confronting even more painful episodes not yet revealed to others. At that point the consulting psychiatrist (JB) noted that the "process" whereby Kasey was reporting these memories in therapy (her affect, body language, etc.) was as important as the "content," but is not easily imparted by speaker phone communication after the fact. This observation seemed to help Kasey's parents to give "the benefit of the doubt" to the therapy staff at the RTF, with accompanying hope that Kasey was indeed making some progress. That meeting ended with a consensus that Kasey would be best served if she were discharged to a host home close enough to the RTF to maintain her current therapist, and that an individualized "recipe" would be devised to meet each of her anticipated needs.

However, at the next meeting 4 weeks later the RTF staff reversed their opinion and iterated their former position that Kasey needed to be close to her adoptive home for intensive family therapy. The RTF also notified the team that the therapist would not be available to continue with Kasey's treatment even if she was placed in a Host Home close to their facility. This news met with a painful silence among the surprised assembly of team members on the other end of the speaker phone hook-up. Despite palpable tension between members of the ISPT, the plan for Kasey to be discharged to a therapeutic home closer to her family was agreed upon.

After the phone connection with the RTF staff terminated, JB took the risk of discussing with the members of the team still present, including Kasey's parents, that perhaps the RTF staff were indeed feeling that the parents were not committed enough to Kasey and her treatment, and were indirectly expressing this via their reversal of opinion. Kasey's parents reaffirmed their devotion to Kasey, and poignantly shared with the team a summary of their chronically and extremely harried life circumstances, including their other special-needs children and the tragic loss of their house to a fire in the relatively recent past. The empathic response of the other team members seemed to actually facilitate a greater empathic appreciation of the difficult circumstances shared by all team members, including the RTF treatment staff. The meeting ended with a discussion of alternative options.

At the fifth ISPT meeting 2 months later, the treatment staff were using the phrases "self-awareness" and "self-reflection" to describe Kasey's evolution in treatment. JB shared with the team his impression that this signaled the beginnings of a critically important ability in

Kasey that is currently being referred to by Peter Fonagy and others as "mentalization." That is, the ability of a person to **reflect** cognitively and affectively on his or her own mental content (perceptions, thoughts, feelings, memories, urges, etc.) is the ultimate salvation from having to be those perceptions, thoughts, feelings...and therefore from *endless acting out*.

Post-discharge planning then proceeded with the understanding that the RTF staff would not continue to be involved in Kasey's care. Kasey's parents also grew to agree with the team consensus that the single most critical feature of the post-discharge treatment team would be its *seasoning, flexibility and theoretical and clinical soundness* rather than adherence to a supposed Reactive Attachment Disorder-specific treatment methodology, without discounting the importance and value of understanding attachment-related pathology and tailoring treatment approaches appropriately. Ironically, the ensuing difficulty in finding a host family with the skill and experience to work with Kasey's challenges provided an extended time for Kasey to remain in the RTF and continue her therapeutic relationships and progress. At the time of this writing Kasey is in a therapeutic host home.

### Reflections of Team Members on the Multidisciplinary/Multi-agency Team Process

At the conclusion of the series of ISPT meetings summarized above, all team members shared a consensus that the process was necessary, personally and professional enriching, and successful in resolving a serious treatment impasse for Kasey. BJ requested that the team members share their reflections on the process at a statewide Children's Interagency Training Conference, and again all members en-

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thusiastically agreed. The aim of the presentation was to share how the family dynamics of a child with RAD and her parents and siblings can be reflected—if not replicated—in the dynamics of the ISPT process. The process described above had to be initiated with the involvement of OMHSAS staff because of the inevitable and extraordinary strain that RAD pathology places on the child, parents and those to whom they look for help. Living with RAD leaves a family feeling isolated and grossly misunderstood. Trying to provide services for a child and family living with RAD often leaves mental health staff feeling inadequate, frustrated and prone to blaming the family for the child's disordered attachments.

The goal of the presentation and this paper is to illustrate that with greater understanding of a diagnosis and the dynamics of the ISPT process a family and their county staff can come together with far greater consensus in good time to establish an effective ISPT team, and generate an effective treatment plan without the need for consultation at the regional or state level. What follows is first a summary of the reflections of the various team members, and then an effort to incorporate these reflections into a discussion of the interactive dynamics of the team process.

#### **Mrs. G**

Kasey's adoptive mother reflected with gracious candor some of her most intimate feelings about Kasey and her adoption. She recalled the "ache" and "hole" she had felt inside when her doctor advised her against any additional pregnancies. But she noted that when the idea of adopting children arose in family discussions, the family was unanimously in favor. She then painfully recalled her growing re-

alization that Kasey, one of the two adopted girls, had serious problems with interpersonal relatedness. Specifically, she recalled Kasey's uncanny way of creating an almost repulsive sense of dissolution of interpersonal boundaries with others: "Holding her, it felt like she was soaking into my body." Mrs. G added that the family's cultural system was not sympathetic to her desire for daughters via adoption, and was accordingly unsupportive when the Gs faced special challenges in raising the girls.

Reflecting on her experiences as a mother involved in the treatment of a child with Reactive Attachment Disorder, she shared two comments: 1) in Kasey's pre-RTF outpatient treatment a prolonged period of holding therapy yielded no noticeable positive results and in fact left her (mother) at times feeling almost "paranoid," and 2) in support group meetings for parents of children with Reactive Attachment Disorder she was exposed to a strong bias against the belief that Pennsylvania's service system—and RTFs in particular—could effectively treat children with that diagnosis.

#### **Mr. G**

Kasey's adoptive father poignantly recalled his anguish that love and hard work alone were not enough to heal Kasey. But he also shared a sound basic understanding as to why, noting that the feeling of being cared for in itself has been impossibly frightening to Kasey. He shared that while he reached the point of acceptance that Kasey might remain too ill to ever return home, Mrs. G—as a mother—could not. Therefore, he sagely saw her eventual insistence that Kasey had to be much healthier before returning home as a positive and necessary milestone in the treatment process.

He offered several salient caveats for clinicians providing treatment for children with Reactive Attachment Disorder. He presented moving examples of his painful struggle to meet the needs of one child while protecting and guarding stability for his remaining children and his wife. He referred to the “ripple effect” of treatment: all involved must consider the effects of the child’s treatment on the rest of the family. He noted the “fraternity effect,” meaning the strong sense of empathic connection maintained by parents of children with that disorder. He underscored the importance of *regular respite* for families working with a child with Reactive Attachment Disorder. And in reflecting on the treatment planning process, he suggested the “wedding cake” analogy: just as no two wedding cakes are ever the same, so must the treatment approach to each child with Reactive Attachment Disorder be individualized to meet the unique needs of that child and her family. Finally, he noted that by the conclusion of the ISPT process, “We are better now. We have *hope*.” This served as a reminder that instilling hope is one of the most important goals of an ISPT process.

### Care Managers/Case Managers

The care manager from the MCO expressed her inevitable conflict between facilitating the best care possible for Kasey and being mindful of her mandates to manage care, contain the cost of treatment and keep the medical assistance dollars within Pennsylvania. She noted that her status as a parent herself facilitated a positive identification with Kasey’s parents while nevertheless intensifying her emotional struggle with the aforementioned natural conflict. She observed the power of the face-to-face team meetings in facilitating the development of a relationship, not just a name on a piece of paper.

The MH/MR case manager also shared very candid feelings. She recalled being “scared” at first at the prospect of assembling a much larger interagency team. She then noted that the initial MH/MR case manager assigned to Kasey’s case was enthusiastic but very new and not skilled at “thinking outside the box.” The county staff acknowledged the value of the ISPT process and recognized that the same process can be used at the county level before tensions build and positions become polarized.

### RTF Treatment Staff

Kasey’s case manager at the RTF also noted the disadvantage of not having been able to see the faces of the team members on the other end of a phone link. He saw the process as entailing the successful coming together of two different teams. He noted his feeling of a growing consensus after the first team meeting in which the RTF staff participated, and felt that the contributions of the Field Office staff “energized” the assembled team. This was an interesting perspective and perception. The ISPT did not so much reach *consensus* about the ensuing post-discharge treatment plan as they did “agree to disagree.” This ability to move forward in relationships despite lingering disagreements is just what children with RAD are *unable* to manage and what treatment teams must model.

Kasey’s supervising psychologist admitted that he was doubtful the RTF could provide adequate treatment for Kasey with her parents living at such a great distance, in that his theoretical and training bias entailed the need for intensive family therapy with the adoptive parents. But he pointed out that the IAT experience illustrates the importance of showing sensitivity to the exigencies and needs of the

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families of children in residential treatment. He also highlighted his sensitivity to potential cultural complications of treatment, with his being Jewish and Kasey's parents Islamic. (In fact, in response to his comment, her parents noted no feelings of cultural bias or insensitivity, affirming the usefulness and importance of the psychologist's mindfulness and his sensitivity to the CASSP principle of cultural competence.) Finally, in addressing the RTF staff's persisting and strong opinion that Kasey should be discharged to services in her home community, he gave an appropriately strong pitch for the establishment of a range of post-adoptive services in all communities, such as his RTF has promoted locally.

### **The Child Advocate**

The member from a child advocacy organization (Parents Involved Network [PIN]) shared her background as a parent of two children of superior intelligence, who nevertheless have struggled with chronic serious mental illness. She shared her feeling that advocacy for dignified mental health treatment for children and adults is for her a "spiritual calling." She acknowledged that while the CASSP process has some problems, this ISPT process illustrated its potential strength in bringing together and galvanizing necessary individuals into an organic unit capable of solving problems. She noted the potential for misuse of terms like "medically necessary treatment," and stressed that the concept should guide the team toward "whatever it takes." As previously cited, she provided a unifying focus at the outset of the meetings by asking Mr. and Mrs. G to share their vision of Kasey's life in her early 20's. This inspired the whole group to focus on Kasey's strengths and potential, and correspondingly more on planning services that would promote

Kasey's reaching her potential than upon past treatment shortcomings. Finally, she issued a reminder that, while treatment team members can come and go, the child's parents are the constant members and after all should be considered as the captains of the team.

### **Discussion**

The preceding vignette illustrates many of the findings regarding effective treatment team functioning cited in the introduction to this paper.

#### ***The "antireductionistic, nonsummative, constructivist" nature of the treatment team as a system:***

Literally all members of this team shared a unique individual perspective without which the resulting treatment plan would not have been nearly as empowered by an informed consensus amongst all parties.

#### ***The flexibility and self-organizing features of an effective treatment team:***

Flexibility is illustrated by the team's freely and imaginatively augmenting the team composition with additional members, such as the patient advocate and parent's chosen guests/supporters, so as to bring in important additional perspectives. This did not bog down the process, as one might fear, but actually facilitated more comprehensive understanding of the scope of Kasey's treatment issues and therefore ultimately more efficient treatment planning. The team was self-organizing in that there was constantly an effective balance between organizing and structuring the meetings and a free flow of observations, information, opinions and ideas, wherein virtually all team members seemed to share a sense of not just the prerogative but the responsibility for participation. BJ

was careful to maintain the role of team *convener* and *facilitator*, at times promoting the active participation of some of the more reticent attendees, and thereby fostering leadership per se as a shared function. In fact, consistent with CASSP principles, Kasey's parents were prominent as co-leaders of the meetings.

This point merits further discussion here, especially in light of the dismayingly frequent and very evident lack of effective leadership in mental health treatment teams. As noted above, BJ's leadership entailed the *convening* and *facilitating* functions necessary for effective team functioning. But others served as leaders for other team functions, some at specific moments—such as the child advocate in setting the “tone” for the meetings—and others more constantly throughout the process, such as the child psychiatrist, who as “participant-observer” monitored, interpreted and empathically confronted the team dynamics. So, it seems best to define *leadership* in interagency teams as the *recognition* by each team member of his or her unique *responsibility* to the child, parents and other team members and the *readiness* to discharge that responsibility.

### ***The importance of balance between morphogenesis and morphostasis in treatment planning:***

One concern often voiced by seasoned child and adolescent psychotherapists is that so much of the discussion of Reactive Attachment Disorder seems like “old wine in new jugs.” That is, they recognize the psychopathology described under this diagnostic rubric and are aware that they have been confronting it in their practices, often successfully, by being appropriately flexible in their psychotherapeutic approach. They therefore question whether there is indeed a distinction between Re-

active Attachment Disorder and Borderline Personality Disorder, or Posttraumatic Stress Disorder with the trauma having occurred in the earliest years of life. Horror stories about novel treatments specific for Reactive Attachment Disorder serve to create even further apprehension over the legitimacy of the diagnosis and its treatment.

What can result is a sort of “false dichotomy,” wherein clinicians, parents and patients (and ultimately perhaps politicians) segregate into two groups, the believers and nonbelievers in Reactive Attachment Disorder. This state of affairs then tends to squelch flexibility and creativity in treatment planning, and the seeking of ideological specificity rather than clinical skill and seasoning in the treatment team.

Kasey's interagency team successfully faced this hazard, neither dismissing the legitimacy of her diagnosis of Reactive Attachment Disorder nor the potential for skilled and seasoned clinicians to adapt traditional treatment approaches in any ways necessary to “meet her where she was at” psychologically and psychosocially.

### ***ISPT process dynamics:***

Finally, the dynamics of this inclusive ISPT process, clearly evident throughout this discussion, nevertheless merit specific reflection. JB was able to maintain a position of “participant-observer” throughout the process. As such he enjoyed the opportunity to be at once detached and objective enough to see the group dynamic unfolding, and on the other hand enough identified as a team member that his comments on the dynamic were welcomed and fruitfully discussed.

Persons with Borderline Personality Disorders and Reactive Attachment Disorders share in common two maladaptive coping (or defense) strategies that enabled their survival earlier in life but cause chaos in their present social lives: **projection (and projective identification)** and **splitting**. In projection intolerable wishes or feelings are automatically (unconsciously) disowned and attributed instead to the external environment. In projective identification the projected wishes or feelings are then attributed to specific other person(s), who are correspondingly at risk for “owning” those feelings. Thus, for example, the patient who deep-down feels helpless in the face of his diabetes, and angry that he has the disease, cooperates poorly with the doctor's recommendations, resulting in the doctor's feeling helpless and angry himself—unless he's really on his toes and recognizes the dynamic of projective identification!

Splitting is an unrealistic and potentially very destructive creation of “false dichotomies”: some people are all good, and some all bad; some are all right, and some all wrong. Splitting presupposes an “either-or” version of reality in a world of shades of gray. Thus, the above patient might at one visit thank the doctor profusely for being the greatest endocrinologist ever, and at the very next visit condemn the doctor for even gently confronting him about his not having his blood sugar levels checked as recommended.

Projective identification and splitting almost inevitably threaten to disrupt the best of treatment teams working with persons with serious mental illness. The persistence of Kasey's severe impairments despite a variety of treatment efforts over time certainly provoked unrealistic feelings of helplessness and hopelessness—and their accompanying and devastating emotion of excessive **shame**—within those de-

voted to her healing. (Experts on the treatment of attachment-disordered children such as Daniel Hughes [2006] emphasize the prominence and malignancy of excessive, indwelling shame in the minds of persons with disturbed attachment capacity. This pathological shame can easily be projected onto others, as they react with various forms of counter-aggression to the child's provocative behavior.) As previously noted, this naturally reified the notion—inadvertently or intentionally promoted in various quarters—that there is a unique and specific treatment approach known only to a few, and that other approaches are doomed to total failure.

At a moment when the RTF treatment team and Kasey's parents appeared imminently likely to identify *each other* as the “real” impediment to Kasey's progress, JB offered the caution that Kasey's internal core sense of helplessness and shame must not “infect” the treatment team. This promoted the return of the team to a unified, empowered treatment planning effort. Further, all team members became ever more mindful of the need to understand Kasey's persisting inappropriate social behavior as the aftermath of a traumatic early life. Thus, the discussions remained free of descriptors of her behavior, such as “manipulative” and “resistive,” that would both signal and promote splitting among members of a treatment team. (Such “interpretations” of the team process must be offered empathically and carefully, to avoid provoking unnecessary feelings of embarrassment at being “caught” in the act of being victimized by projective identification and splitting. Such would of course be likely to result in defensive withdrawal rather than identification with the group.)

## Conclusion

Psychodynamic theory recognizes **conflict** as natural and normal, and **compromise formation** as the means to healthy management of conflict. Most conflicts are insoluble but manageable: we cannot solve the dilemma of whether to stay in bed or arise, because each has its merits; we can at best manage a suitable compromise—stay in bed just long enough to achieve that modicum of extra rest or seek a felicitous ending to that interrupted dream, then get up in time to meet the challenges of the day and strive for accomplishments! So it is with treatment team decision-making, as illustrated in this paper. Antithetical ideas and feelings were accepted as natural and necessary, and the treatment planning process became a synthesizing one wherein compromises were not seen and felt as losses but as ways of preserving the essence of antithetical ideas.

Like D. W. Winnicott's concept of the "good enough mother" as the best mother, the "good enough treatment plan" can be held up as the objective for the treatment team, as it would "best" satisfy the needs of naturally conflicting interests without sacrificing the essence of any one of them. Thus, Kasey's plan satisfactorily addressed **both** her parents' need to see that her attachment pathology were being addressed by persons informed about and skilled at addressing that pathology, **and** the need for fiscal conservation, **and** the need for treatment in a home with a caring adult where Kasey's family can participate in her treatment, and Kasey's continuing need for placement outside the home, etc.

Mental health treatment planning routinely attempts the nearly impossible: intervening with the most complex organized system in the universe—the in-

dividual human being in relation to others. This necessitates a paradigm for the treatment planning process that is inclusive of all relevant parties, fluid over time and space, and flexible. **Indeed, within such a process opposing perspectives need not be felt as antithetical but instead as complementary, and the inclusion of the essence of each not as compromise but as synthesis.**

As we anticipate the further evolution of mental health treatment planning methodology, the roles of the case manager and the psychiatrist in the treatment team merit special scrutiny. The case manager in modern treatment systems must exert his or her leadership in convening and facilitating the development of an effective treatment team, and then monitoring the treatment team process.

The psychiatrist should be expected to be able to develop and share an understanding of the individual that elucidates the dynamic interaction of the biological, psychological, social/cultural, developmental and spiritual dimensions of that individual's life. Our experience suggests that the properly trained psychiatrist is in an optimum position to serve as the "participant-observer" on the team, ready and able to watch—and feel!—the unique dynamic of each team as it unfolds in the course of planning for the needs of yet one more unique and very complex individual, and to clarify and interpret that dynamic to keep the pathway clear to an optimum synthesis—the good enough treatment plan.

The child psychiatrist, along with the committed interagency service planning team as a whole, is therefore the enemy of despair, the preserver of hope. To serve this function, he or she needs to have excellent training in understanding human system dynamics in general and the psychodynamics of treatment teams in partic-

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ular, and then ample practical experience in applying this understanding effectively as a member of treatment teams. Further, such an understanding and practicum must permeate not only psychiatric residency training programs, but **all** graduate programs in the allied mental health professions. For each type of professional bears their own unique set of skills and responsibilities, and therefore their own role in the co-leadership of teams devoted to the recovery and wellness of our children and youth and their families.

Inclusive multidisciplinary service planning teams, mindful of their dynamics, strengths and potential pitfalls as discussed above, will lead to optimum and timely treatments and outcomes for children with severe and complex diagnoses. Therefore, they need to be supported and expected by MCOs, other payers and all mental health “stakeholders” who insist on specifically including members of the clinical staff. In the instance of Reactive Attachment Disorder, optimum treatment occurs *within the context of the family* in a flexi-

*ble, community-based* treatment regimen guided by *seasoned clinicians*. While sometimes residential treatment for children with Reactive Attachment Disorder is necessary, this article illustrates the extra burdens placed on all members of the team—not the least of which are the child and family—when treatment moves to the residential setting. Nevertheless, phone conferencing was clearly helpful in the above-described situation, and video-conferencing technology may prove even more helpful in those—hopefully infrequent—situations wherein the family and/or members of the multidisciplinary team are distant from the facility.

Finally, we would make specific note of the fact that the interagency service planning team process described above was marked by its *persistence* in pursuing satisfactory care for the child and family. Perhaps a team and its members can provide no one commodity more important than the hope that such persistence reflects and instills.

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## REFERENCES

- Boaden, N. & Leaviss, J. (2000). Putting teamwork in context. *Medical Education*, 34 (11), 921-927.
- Butterill, D., O'Hanlon, J., & Book, H. (1992). When the system is the problem, don't blame the patient: Problems inherent in the interdisciplinary inpatient team. *Canadian Journal of Psychiatry*, 37 (3), 168-172.
- DeCivita, M. & Dobkin, P.L. (2004). Pediatric adherence as a multidimensional and dynamic construct, involving a triadic partnership. *Journal of Pediatric Psychology*, 29 (3), 157-169.
- Hughes, D. (2006). *Building the Bonds of Attachment: Awakening Love in Deeply Troubled Children*. 2nd ed. New York: Jason Aronson.
- Iedema, R., Meyerkort, S., & White, L. (2005). Emergent modes of work and communities of practice. *Health Services Management Research*, 18 (1), 13-24.
- Madge, S. & Khair, K. (2000). Multidisciplinary teams in the United Kingdom: Problems and solutions. *Journal of Pediatric Nursing*, 15(2), 131-134.
- Perl, E. (1997). Treatment team in conflict: The wishes for and risks of consensus. *Psychiatry*, 60 (2), 182-195.
- Reinharz, S. & Lowental, U. (1979). Group dynamics in community health teams. *Journal of Community Psychology*, 7 (2), 104-110.
- Rodenhauser, P. (1996). Psychiatrists as treatment team leaders: Pitfalls and rewards. *Psychiatric Quarterly*, 67 (1), 11-31.
- Rosenheck, R. (1988). System dynamics in complex psychiatric treatment organizations. *Psychiatry*, 51(2), 211-20.
- Sadock, B.J. & Sadock, V.A., eds. (2000). *Comprehensive Textbook of Psychiatry*. Philadelphia: Lippincott, Williams and Wilkins. p. 2160.
- Shabbir, M. & Banerjee, S. (2004). Clinical management: Where medicine meets management: Reduced circumstances. *Health Services Journal*, 114 (5913), 24-25.
- Yank, G.R., Barber, J.W., Hargrove, D.S., & Whitt, P.D. (1992). The mental health treatment team as a work group: Team dynamics and the role of the leader. *Psychiatry* 55 (3), 250-264.

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