



Treatment Protocol

Philosophy

Attachment begins at conception and naturally occurs before the age of four in children who are given the opportunity to do so. Attachment cannot be formed in isolation, however, so a young child's development is influenced by those who care for him. If an appropriate, consistent and responsive primary caregiver is available to that child during these early years, attachment will naturally develop.

For those children who do not have this experience, their way of looking at the world is distorted and destructive. They come from a perspective that states the world is a dangerous place, and unless the child is in control of everyone and everything in their environment, he will die. He has a negative self concept, thinking he is inherently bad, and he can trust no one, relying solely on his own resources.

Our goal is to restructure those internal beliefs to more accurately reflect the belief system of the attached child. We attempt to help the child realize that the beliefs he is so desperately holding onto are actually making his life harder. That the development of his particular beliefs was understandable and acceptable, given his early life experiences, but now, in his present situation, they are no longer meeting his needs and are, in fact, causing him difficulty in obtaining his goals.

Description of Processes

Intake / Admission:

Information is gathered via telephone contact with the primary caregiver or person responsible for the child's care, prior to meeting for the first time to determine that our services would be appropriate for the child. Situations that would be referred elsewhere would include those where the family is not motivated to participate in the work necessary to heal the child. The family would also be referred to other services if one or both of the parents were not willing to accept the general premise of attachment disorder

and that it is necessary for the parents to work together, or at the least, be mutually supportive, in order for the child to heal.

Assessment:

During the assessment session, an in depth interview is done to gather all pertinent history on the child and the current family situation. Additional resources for gathering information would include state agencies, other treatment providers, educational facilities, past caregivers and any other available resources. Copies of past evaluations and reports will also be requested in order to develop a full and accurate portrayal of the child's presenting condition.

Various tools would be used as appropriate for the situation including the RADQ, the Vineland, the Antisocial Process Screening Device, and/or the Child Behavior Rating Scale. The child is also directed to draw three pictures, a 7 item drawing (person, tree, house, bird, snake, water and sun), a kinetic family drawing and a drawing of his choice. All of this material is used to determine the client's current level of functioning, his strengths and weaknesses.

Parents would also be asked about their attachment backgrounds to help identify triggers and buttons being pushed by the child so that a plan can be developed to meet the needs of the entire family as related to the impact of the client on the family system and the system on the child.

Treatment Planning:

Prior to developing the treatment plan, the client will have acknowledged that he is having difficulty in his life and that he wants to do the work necessary to improve his current situation and the way he is choosing to live his life. A verbal contract is agreed upon with all parties that states that the parents and therapist will work as hard to help the client as the client is willing to work to help himself.

Once this agreement is reached, a treatment plan will be developed to meet the particular needs and issues of the child individually and in the context of the family. Goals will be developed to address attachment, changing the child's thinking patterns, changing the child's thinking, healing the parents, teaching new parenting strategies, and other clinical issues related to coexisting conditions.

The treatment plan will then be reviewed and discussed by all parties. Ongoing evaluation and assessment will be used to ensure that interventions are effective and appropriate to the child and the family situation.

Treatment Techniques Used:

See the attached checklist for the techniques and interventions employed in providing services.

Safety/Risk Management Plan:

Safety is maintained in the office by having the client video monitored whenever he is not in the presence of his parents. The child's parents are also able to view and hear all interactions between the therapist and the child through closed circuit cameras in the therapy room that the parents can observe on a monitor in the observation room. Coercion and antagonizing the client are not engaged in and strong emotions are addressed in the context of a safe, respectful environment.

In the event that a client becomes disregulated, the foremost goal is to keep the child physically, emotionally and psychologically safe at all times. Every attempt will be made to therapeutically process through the emotional upheaval with the child, supporting and encouraging him while providing a safe environment for him to express his strongest emotions. If a child becomes physically aggressive or violent, he will be restrained using the least restrictive measures possible, to ensure his safety and the safety of all parties present. The client will be restrained until such time as he is able to control his physical actions and no longer provides a threat to either himself or others. The safety principles of the ATTACH Professional Practice Manual will be adhered to at all times.

Evaluation / Outcomes / Follow-Up:

The goal of our treatment is for the child to internalize his loving parents, to learn how to love in return and to trust his parents, therefore allowing for future loving relationships. We also strive to enable successful completion of developmental tasks that were negatively impacted by the child's history which will increase the child's degree of personal accountability and responsibility.

Progress is determined through discussions with both the client and the parents regarding changes in the child's behaviors, attitudes and thought processes. Other forms of evaluation include drawings made by the child, and reports from the child's school or other community activities the child is able to participate in. The therapist will witness an improvement in the way that the child and parents are relating to each other in the office as well as reports of interactions outside of the office.

Outcomes of the practice are monitored with end of service evaluations primarily consisting of retest scores of the original tools used and verbal reports by parents and the client. Video tapes of sessions have also been compared to demonstrate progress a client has made over time. Follow-up is done through periodic communication with phone calls and written evaluations after the completion of services. This contact takes place at 3 months, 6 months and annually after a client is discharged from the agency.