Lesa Arvia – Treatment Protocol

Philosophy:

I believe that when working with children and families with attachment disorder you have to respect the struggles and difficulties that not only the children have but that the caregiver's go through. In working with attachment disordered children and families I have learned that many families feel that others do not value their judgments. I believe that the families are the key to change and that we all have to work as a team. It is not only important to work with children but also to prepare and support the families. Rarely do I see a child individually.

Attachment is on a spectrum and there are many factors that can influence the security of the attachment. Through the assessment process we will learn the level of attachment and begin to work to strengthen it through parenting and trauma work. I believe that change is possible and that there is hope.

Intake/Admissions:

Initially I do a thorough assessment taking in information to learn about the child's development and history. I learn about the presenting symptoms (problems) and the strategies that both the parents and children use when interacting. I prepare parent's for attachment therapy as it is different than traditional therapies. When the child is in the session I do a lot of holding and safe touching. Limits are firm but I also respect that a child may choose not to work on his life. If this choice is made I will help the family to have less chaos and more peace in the home, even if their child is not working on their life. In sessions parents will often hold their child and again I work in unison with parent's to establish a strong attachment. I will refer to a more restrictive environment if necessary but use that is a last alternative.

Assessment:

At the initial intake there is agency paperwork to fill out. This includes consents for treatment, a client contract, any necessary releases of information and information on HIPPA requirements (privacy laws). Who ever has guardianship of the child must sign a consent that allows the child to participate in therapy – for instance – a child in foster care would need a caseworker to sign for treatment.

At the initial intake much of the hour session is spent with the caregivers. Information is gathered on birth family history/care taker history – this information includes own relational patterns, caregivers relationship and childhood history. When talking about the child information is gathered on the pregnancy, delivery, and developmental milestones – for instance: time of toilet training, stress during pregnancy, separations etc.

We discuss educational history and interactions with other adults and children. If the family has had any psychological or educational assessments completed they are asked to

bring that with them or to sign a release to obtain them. The family is asked to discuss issues they have with the educational system and needs they notice with their children.

We discuss child's behaviors and caregivers responses to them. Information is also gathered on trauma related issues and patterns of relating to others. Trauma related issues may be frequent separations, medical problems early on, abuse or neglect. It is also important to talk about treatment history – successes or disappointments.

Medical issues will be addressed and if needed a referral will be made to a staff psychiatrist. I also work with other psychiatrists in the area if the family feels they want to continue to maintain that relationship. I also work with primary care doctors if necessary.

Treatment planning:

Within the first couple of sessions a verbal contract (sometimes written) is set up with the child and family. This contract talks about the child's willingness to work on their life. Most children make a verbal contract which they later need to be reminded of. Families are also asked to make a verbal contract/commitment to work hard in treatment. I also address that there are times that the family and the child will have to do it my way. Please know that I will never suggest a strategy that puts anyone in physical harm.

Treatment techniques:

I use several strategies to work with children and their families, as I have found that some attachment disordered children are able to adapt quickly. We work on eye contact, safe touch, empathy and affective attunement. I will encourage the families to use paradoxical strategies when at home and in session. Families will be encouraged to practice these strategies at home with their children. I will confront children when they are not being truthful, while always remaining empathetic to their behaviors. I am firm but playful. I use a great deal of humor in sessions along with tickling and hugs.

Safety management:

The office that I see children and families in has a couch, two chairs and a table. There are times when children get angry and agitated. I, along with the families have been able to manage behaviors to ensure the safety of everyone in the office. Psychologically I keep children and families safe by pacing. Many of these children and some parents have a great deal of trauma in their lives. I believe that I would be re-traumatizing people if I did not pace the sessions. By this I mean that we bring out difficult material and manage his/her affect before moving on. It is my job to help people to regulate their moods and not be constantly overwhelmed. In session we practice positive coping skills which can be used at home, work and in school.

Evaluation process:

I do not have a formal evaluation tool that is used. I rely on caregivers to talk about progress and will also check in with schools and other collaterals. Much of my tracking of the successes come from caregivers as they are the ones who live with and know their child the best. If something is not working we come up with other strategies or explore why it may not be working. All people/families are different – what works for one may not work for another.