

Philosophy: To provide families with a safe and effective attachment therapy that is derived from a systematic perspective involving assessment and interventions in the spiritual, emotional, physical and social realm with a Christian worldview. The parents and I collaborate together as a team on all decisions about treatment, taking into account their needs, opinions and most of all their safety. My treatment is never coercive. The entire family is respected and their well being and safety is my utmost concern. The goal of treatment is to provide positive relationship changes in the individual and family.

My philosophy of treatment is anchored in the knowledge and belief that our Lord Jesus Christ is the ultimate source of healing and I am His instrument.

Description of processes:

Intake/admission: A family's suitability for treatment is determined in the intake when I review the child's history as well as the parent's willingness to participate in the therapeutic process. I have each parent fill out a symptom checklist on the child. I collect school histories and reports, medical history: past and current medication, treatment history and all prior diagnoses, and a history of disruptions and moves. I have discussions with parents for concise explanations concerning attachment history. If a child is not truly attachment disordered, referrals are suggested elsewhere. If a child, other family member or any treatment team member would not be safe during the treatment then other options are explored. If the child/teen makes minimal progress over the course of the first 3-6 months, a 2 week intensive is recommended and referrals are made. If the family does not appear motivated for the difficult work in store, other possibilities are discussed such as marital counseling.

Assessment: I continue to review all the information with the parents on the initial session. This enhances the joining/rapport building process. A systems approach to treatment allows us to continue to assess all members of the family; their needs and behavior and how they impact one another and how that affects the unit as a whole. Assessment of the progress, which has occurred (or lack of) during treatment, is a critical part of moving forward towards what ever may next be indicated. This progressive approach insures greater success and is ultimately most respectful of the clients.

Treatment Planning: Assessment and subsequent treatment planning and modification unfold throughout the entire intensive. The basic road map is planed out with the parents at the start and revised as needed. Treatment planning involves the child (depending upon resistance) by asking them how their life is going, are they interested in working on it, and in what areas do they think they need help. This starts a problem list or contract, which we add to as the issues go deeper. Ongoing contracting occurs during all phases of therapy in order to promote honesty and install feelings of ownership regarding the outcome of their treatment.

Treatment Techniques:

- Nurturing Cradle Hold- simulates mother/infant interactions, healthy touch.
- First year of life cycle- discuss what they needed and didn't get even before birth.
- Sentence Completion Form- to assess functioning, identity, and resistance.
- Problem list created by child and therapist for rapport, assessment, and contracting.
- Cognitive Restructuring.
- Contracting/joining- on-going part of assessment and treatment planning.
- Up-regulation/down-regulation-safe structure for expressing painful emotions that can lead to attunement, healing connection and attachment.
- Physical and emotional feeling identification and expression.
- Apology, forgiveness and acceptance practice.
- Parent/child communication and reciprocity.
- Marital/communication counseling.
- Parent's childhood work.
- Parent education with on-going feedback regarding what occurred between each session.
- Homework is assigned when indicated.
- Prayer during treatment as indicated.

Safety/risk management plan:

I spend time with parents on the phone so they know what therapy is and what it is not. Holding is always done in a nurturing, cradling fashion and utilizes the parents whenever possible and indicated. It is *never* coercive! When the parents are not in the treatment room participating, they are watching via closed circuit tv in the next room.

Evaluation/follow up:

To evaluate progress the symptom checklist is used after treatment with the before and after results rated. I follow up with on-going phone contact and encourage non—scheduled informal contact.