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Treatment Protocol

Mission Statement:

Giving Hope, creating strength, empowering lives through treatment, education, and support.

Philosophy:

The philosophy of therapy is to enable the healing a child with Reactive Attachment Disorder and family through a multifaceted outpatient approach. We seek to heal the child through object-relations therapy, trauma resolution, and psycho-education. We seek to help families through encouraging healthy family relationships while healing wounds and teaching more effective parenting strategies designed to eliminate destructive and aggressive behavior.

Description of processes:

Intake/Admission:

The admission process begins with an in-depth application. The application gathers demographics for mother, father, child, and others living in the home. Medical information and any significant information related to the family with regard to medical issues is also gathered.

Another part of the admission process is gathering information on the family of origin history for the child, including dates of last contact, termination of parental rights, occupations, criminal history, and whether or not the child knows this information. History regarding the child's prenatal, birth, developmental, placements, educational history, mental health treatment history, psychotropic medication history and medical history are also part of the initial intake.

Assessment:

Parents fill out an RADQ, TJTA, and Cline Helding Adopted/Foster Child Assessment, Child Behavior Check List and other protocols, along with a narrative regarding a typical day with the child. Parents also write narratives (autobiographies) for themselves with particular attention to their own families of origin, why/how they came to have this child, and how their lives have changed since the child came to live with them. They are asked to include their expectations for therapy. Children fill out a Sentence Completion and Drawing assessment, and projective drawings.

A complete medical, educational, developmental, and psychological history for the child is included in the assessment along with any significant issues for family members.

The goal is to assess the strengths of the family and the child. These assessments and histories are reviewed prior to planning a treatment course of action.

Treatment planning:

The planning involves reviewing all of the intake and assessment information and a minimum of two interviews with parents only to develop an overall plan for intervention. Parents are essential members of the treatment team that includes therapists, the child, and input from medical personnel and psychiatrists. Informed consent of the client and family regarding release of medical records, safety issues, and treatment techniques is also a part of treatment planning.

Generic plans for families/children include building trust, empathy, attunement, communication skills, and reciprocal behaviors. Another goal for the family is to increase the quality of physical and emotional closeness through the use of positive touch, nurturing, and humor and playfulness.

Treatment Techniques:

For the child and family:

a. Use of supportive language and cognitive therapy, cognitive behavioral therapy to create a safe, nurturing, and empathetic climate for therapy.

b. Planning and facilitating ongoing monitoring and education to maximize attunement, parenting skills, and trust.

For the child:

A full range of therapeutic techniques are employed to ultimately help the child willingly and appropriately surrender control to parents in a healthy way while increasing the child's readiness to rely on the parent for safety, help, comforting, and nurturing. These techniques include:

a. Kinetic activity that is diagnostic and enjoyable for the child includes drawings, clay art, play activities, and nurturing time with parents in a controlled directive setting.

b. Therapeutic contracting for behavior management, and goals, written and verbal.

c. Homework: journaling when appropriate, assignment of responsibilities with a representative inner-child, i.e., teddy bear, stuffed animal.

d. Parents participating in nurturing time: peaceful holding, cuddling, early childhood games, bottle time, and puppet games to facilitate emotional development.

e. Therapist uses nurturing holding in a non-coercive manner when appropriate during discussions of difficult subjects to allow the child to be emotionally available and feel safe for emotionally difficult work.

f. Psychodrama, confrontation of behaviors and faulty thinking, and integration of body, feelings, and mind are used as needed.

g. When available birth parent letters, court records, and other documents are used to help the child understand birth and early childhood history.

h. Consulting with a child to help them make better choices and create a link for cause and effect thinking that leads to reciprocity.

For Parents:

a. Education regarding parenting with regard to a with Reactive Attachment Disorder.children. Education includes learning to achieve a healthy balance of boundaries, nurturing, encouragement, and disengagement from unnecessary control battles. This process also develops interactions that establish a healthy attachment through smiles, eye contact, tone of voice, and other non-verbal forms of communication.

b. Supportive cognitive therapy to unlock their own frustrations, disappointments, and hurts as well as to express their own emotional responses to past/present situations. Therapy also supports the parents need to maintain control over the family environment while assisting the child to feel safe enough to relinquish his/her compulsive need to be in control.

c. Parents participate in sessions, in the room with the child and/or watching from another room.

d. Homework for parents; journaling and weekly updates to therapist via phone or email prior to therapy session.

e. Referrals for parental marital therapy and/or treatment for medical/emotional issues requiring medication, and more in-depth training, i.e., brain gym, are made as needed.

f. Consistent monitoring of parental emotional response to therapy.

For Siblings:

a. Individual therapy as needed to help a sibling express emotional responses, frustrations, and hurts to past/present situations.

b. Inclusion of siblings in family therapy sessions to ensure that all members of the family are responding in a healthy way to the therapeutic process.

Safety/risk management plan:

Safety and risk management are high priorities and are clearly defined and constantly monitored.

a. All participants ensure that the physical and emotional health and welfare of everyone involved in an intervention is monitored at all times.

b. A child is never restrained or has pressure put on them in such a manner that interferes with basic life functions.

c. Parents and/or other individuals who participate observe and monitor the therapy process.

d. While some forms of touch are appropriate and useful, sexual touch is never used.

e. No form of shaming, demeaning, or degrading interaction is used as therapeutic interventions.

f. Treatment options, i.e., nutritive holding, sitting, paradoxical interventions, confrontations, are never used as punishment.

Evaluations/outcomes/follow-up:

At the assessment phase of treatment, parents fill out an RADQ and give verbal/written reports regarding a child's behaviors and the effect of the child on the entire family unit. During the mid-point of the therapeutic process, these assessments/reports are asked for again. When families determine that they no longer need structured therapy, the assessments/reports are given again. This allows us to monitor progress and record length and course of treatment. Every three months the treatment plan is re-evaluated to evaluate or change the treatment plan as needed.

Follow-up will be done with parents and children. It will include contact at six months and then at a year after treatment for verbal assessments regarding the maintenance of positive treatment outcomes and/or opportunity for further therapy as needed. Assessment will be made to determine if more direct intervention is needed.