

Linda Eaton, LMHC
Adoption Related Services of Pinellas, Inc.
8800 49th Street N. Suite 212
Pinellas Park, FL 33782
Phone: (727) 423-7811
Fax: (727) 865-5178
E-Mail: leaton@arsponline.org
Website: arsponline.org

ATTACH
P.O. Box 11347
Columbia, SC 29211

ATTACH Registration Application

Treatment Protocol

Treatment Philosophy:

A child's primary attachment is the foundation for all future relationships and is critical in human development. When a child has experienced a disruption in the attachment cycle, every effort should be made to repair the damage and create a healthy attachment with a responsible, trustworthy caregiver. Provision of attachment-focused therapy is dependent on the prognosis for successful treatment and determination of the child's best interest.

Description of Services:

The intake/admission process includes obtaining informed consent to treat and review of privacy practices and client rights and responsibilities. The assessment phase of treatment includes gathering information both on forms completed by the parents and through interview and observation with the family. An intake information form is used to gather historical information about placement history, developmental information, attachment history, treatment history, medical history and educational history. Behavior checklists, parent reports, and observational data are used in making a diagnosis. These may include diagnostic criteria checklists, sensory integration screening questionnaire, and a sentence completion form. Additional screening forms that are often used in cases where Reactive Attachment Disorder is suspected include the attachment rubric, lifescipt and parenting profile for developing attachment. The Marschak Interaction Method may also be used in the assessment phase to assess parent-child interaction patterns. The Attachment Story Completion Task may be used to assess the child's thought patterns and beliefs about attachment and caregiver-child relationships.

The treatment planning phase includes developing goals, measurable objectives, and discharge criteria that are individualized to the needs of the child and family and are specific to the identified behaviors and diagnoses of the child. Treatment planning is always done in collaboration with the child and/or parents and the treatment plan includes their desired goals.

Treatment interventions can be modified to specifically meet the needs and/or co-morbid diagnoses of the child and family. Treatment techniques are determined based on the level of the child's compliance, age and symptoms. However, the least intrusive techniques are always utilized first and it is made clear to the child and family that attachment interventions are never used as a form of punishment. Verbal contracting is used with all clients involved in attachment therapy. Additional interventions include education about Reactive Attachment Disorder and specialized parenting techniques, lifebooks, timelines, cognitive/behavioral therapy, paradoxical interventions,

bibliotherapy, bonding exercises, nurturing holdings and psychodrama. Case consultation is sought from other attachment-focused therapists and through the ATTACH listserv on difficult cases as needed.

Safety / Risk Management Plan:

During attachment therapy, parents participate in or observe the therapy process. If, during this process, a child becomes physically aggressive, verbal de-escalation techniques are utilized first. The parent is encouraged to assist in facilitating re-regulation through verbal or physical contact. Interventions that interfere with breathing, circulation, or basic life functions are never utilized. If a child is not able to gain self-control and continues to exhibit physical aggression toward self or others, the local police department may be notified. If necessary, the child will be involuntarily hospitalized for crisis stabilization. If there is ongoing risk, a written safety or risk management plan is created to ensure the safety of the child and family.

Evaluations / Outcomes / Follow-up:

Progress in treatment is assessed at least every six months via treatment plan reviews. Progress toward each goal/objective is evaluated and changes are made as needed. In attachment-focused therapy, progress is also measured through periodic attachment questionnaires (i.e., parenting profile for developing attachment and attachment rubric).

The average length of treatment is one year. If appropriate, families are referred for additional services and/or support. When treatment ends, clients are informed that they can reopen their case at any time in the future if necessary. Therefore, follow-up treatment is only provided when the case is reopened. However, families are encouraged to seek ongoing support following discharge.