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Attachment Therapy Treatment Protocol -- Submitted 1/21/2016

Philosophy: Adoptive and foster parents are eager to welcome a child into their home and hearts. Sometimes they need extra help with the special attachment challenges these children can present. Typical symptoms of attachment problems are a child who distances emotionally from primary caregivers or misbehaves in extreme ways. Often children with attachment difficulties have suffered trauma, abuse, neglect or frequent changes in caregiver in early in life. These traumas may result in a child's failure to successfully navigate life's first developmental hurdle – building trust. Children with attachment difficulties bring a template of negative beliefs into all future relationships, even those where love is abundantly available. This template includes core beliefs in which the child believes caregivers cannot be trusted, that s/he will inevitably be abandoned, and that s/he themselves are unworthy and unlovable. Attempts by caregivers to increase closeness trigger in the child fear, distancing and acting out behaviors as the child attempts to protect themselves from the abandonment he or she fears. In Dyadic Developmental Attachment Therapy the therapist facilitates a restorative, corrective set of parent-child experiences which actively seek to repair the break in attachment and trust. Attachment progress occurs when the child is increasingly able to trust, relinquish control, allow comforting by parents, have empathy for others, and take responsibility for actions.

Description of Processes:

I rely primarily on the Dyadic Developmental Attachment Therapy taught by Dr. Dan Hughes, PhD., a leading attachment therapist and educator. First, the work is dyadic, meaning it takes place in the dyad between parent and child. Since the early attachment problems first were created in a problematic relationship to primary caregivers, the healing must take place in session (and at home) in the primary relationship with foster/adoptive parents. In session I work with parents and child to create active emotional connection. Second, the treatment is developmental, meaning that parent and therapist are growing the child through a developmental phase that was missed earlier. This is accomplished first through educating parents about the unique needs of their child and teaching them a set of emotional attunement and limit setting skills to help the child form a more secure attachment. The work relies on key therapeutic principles including empathy, emotional attunement, playfulness, curiosity and acceptance. The main working models I employ are based on the connective work of Dr. Dan Hughes, and the skill building techniques of Nancy Thomas.

Assessment

I meet with fost/adopt parents for an extensive intake interview. Parents complete Terry Levy's Symptom Checklist, Dr. Elizabeth Randolph's RADQ, and child and adult Beck Depression Inventories. I gather historical information and observe the child to complete a comprehensive picture of the child's history, strengths and vulnerabilities. Of particular importance are key factors in the child's attachment history including pre-birth health of

mother and child, episodes of neglect, abuse or trauma, previous placements with prior caregivers, and the child's behavioral and emotional presentation at present. Special attention is given to understanding the child's present functioning within the family. The assessment also includes:

Social & Psychological History

Educational History (May contact teachers/school counselor with parental consent)

Medical History (May contact child's pediatrician with parental consent)

Prior Therapy Treatment (May contact prior therapists with parental consent)

From these sources, a diagnosis is formulated and discussed with parents/caregivers.

Treatment Planning: Parents/caregivers play a big role in the treatment planning process. Common goals include facilitating bonding and attachment experiences between parent and child in session and at home; helping parents with limit setting and effective discipline; assisting the child in sharing inner experiences with parents; increasing eye contact and behaviors of affection; and reducing hoarding, stealing, lying or other acting out behaviors. Special emphasis is paid to supporting parents in a positive, encouraging ways with the unique challenges these children present.

Treatment Techniques Used:

I have trained extensively with Dr. Dan Hughes and utilize his Dyadic Developmental Attachment Therapy. All sessions are conducted with parent and child in the room together. I help increase attachment by:

- 1) Facilitating active attachment experiences in session between parent and child through active direction
- 2) Creating moments of connection through humor, curiosity, playfulness and acceptance in each session.
- 3) Supporting parents in learning and practicing key tools of emotional attunement
- 4) Helping parents learn a set of skills to help their child cope with difficult emotions and decrease acting out.
- 5) Increasing the child's receptiveness to attaching by reducing their inner sense of shame
- 6) Educating parents about the unique needs of their child and how to set limits and intervene with increased skill.
- 7) Engaging the child and parents together with play, sand tray and creative activities.

My work is drawn from leading attachment theorists and practitioners including Daniel Hughes, Nancy Thomas, Holly van Gulden and Nancy Verrier.

Safety/Risk Management Plan: Consistent with my training to "first do no harm" I aspire to use good clinical judgment to insure that interventions protect both parent and child's psychological, emotional and physical safety. Parents are always present and involved in any therapeutic work involving their child. All participants are informed of the rules of therapy – the first being that no one and no things get hurt. Should an escalation of anger arise, I work actively to de-escalate it through appropriate and safe

anger reduction tools such as breathing, pounding on a pillow, etc. If there is any indication that any participant's safety is at risk, interventions are adjusted or terminated. Children are not restrained and no form of shaming, demeaning or degrading interaction is part of the treatment.

Evaluation/Outcomes/follow-up:

Progress is measured by how parents and teachers experience changes in the child's behavior. Behavioral changes are tracked using parent reports on symptom checklists, by evaluating progress in conscience development, and by the child relying on parents for soothing and affect co-regulation. I contact parents at periodic intervals following treatment to ascertain the degree to which clinical gains have been maintained. I also make referrals during treatment and in post care to a local support group for parents of RAD children. This is an important ongoing educational and emotional support.