Institute For Attachment & Child Development
Saving Children. Saving Families. Saving Lives

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http://www.instituteforattachment.org/

We are a licensed, non-profit, internationally recognized treatment, training and child placement agency. We have successfully treated thousands of children with Attachment Disorder since our inception in 1972.

With the purchase of the Evergreen Conference Center in 1994, The Institute for Attachment & Child Development ("IACD") fulfilled several dreams. We now have a "home" for our program, accomodations for visiting families, and a facility to train others in this important work. In addition, by making the Evergreen Conference Center available for the use of the public, this facility serves as a resource to financially support IACD's therapeutic work and serves to connect IACD to the greater community.

We believe in a coordinated team approach to treating each child in our care. Every member of the team is critical to the success of treatment. Our team represents a unique blend of knowledge, experience, skill and caring.

Mission Statement

We are committed to transforming the lives of children with attachment, behavioral and emotional disorders and their families, and promoting healthy family relationships.

Values Statement

Provide quality treatment for families & children with attachment, behavioral and emotional disorders
Advocate for supportive, responsive communities
Research effective treatment methods
Educate about causes, effects & prevention of attachment, behavioral and emotional disorders
Nurture and empower families
Train professionals in the assessment and treatment of families and children with attachment, behavioral and emotional disorders

TREATMENT SERVICES:

- Assessments
- Out-patient therapy
- Psychiatric Evaluation and Medication Monitoring
- Respite
- Child and Adult Intensives
- Sex Offender Treatment

Extended Treatment (Therapeutic Foster Care)
Support, Supervision and Permanent Placement (Therapeutic Foster Care)
Reintegration Services
Parenting Mentoring
On-Site & Off-site Treatment for Attachment Disorder (On-campus lodging available for families)
Ancillary Treatment Services(Neurofeedback, EMDR, Equine Therapy)
Therapist Training (On-Site & Off-Site)
Professional Workshops for Professionals & Parents(On-Site & Off-Site)
Internships for Graduate StudentsResearch Data available for Graduate Students

TREATMENT PROTOCOL

PROBLEM STATEMENT: Children who have not developed an attachment to a primary care-giver during the first 2-3 years of life are arrested in their development. They do not trust, are unable to give and receive genuine affection, are not reciprocal in relationships, lack cause and effect thinking, lack remorse when they hurt others and can be very manipulative, aggressive, and destructive in their behavior. These children do not benefit from traditional talk or play therapy which relies on mutual trust, internal conflict and emotional honesty. These children left untreated become over-represented in the prison and criminal justice population, domestic violence situations, homeless and mental health populations. These children can be helped through specialized treatment described as attachment therapy. Children with attachment disorder have their greatest difficulty in family settings, where respect and reciprocal interactions are expected.

PHILOSOPHY: We believe that these children can be helped. We believe in the healing that occurs in a therapeutic family setting. We believe that parents can learn new strategies for helping their child to heal. We believe in the critical importance of a strong, supportive community. We believe in a multi-disciplinary and consistent team approach to treatment. We believe that the therapy must be a corrective experience for the child, with a focus on helping the child and parents develop the attachment essential for healthy development. We believe that therapy must be developmentally appropriate to the child's emotional level of development.

TARGET POPULATION: Children (from 0 - 18) with disruptive behavioral and emotional problems rooted in early trauma, and the families they live with. Each child is assessed individually, and all factors are taken into consideration. Consideration must be given to the following: ability of the child to engage in treatment (intellectual considerations, level of reality testing, level of conflict regarding behavior). Approval for treatment is based on appropriateness of this treatment for the child and family, NOT on the basis of race, religion, ethnicity, gender, or sexual orientation. A primary consideration for admission into the program is the safety issue – can we keep the child safe, will the family and others in placement be safe. Factors considered include: size/strength of child; level of violence by history; high risk behaviors such as sexual perpetration, fire-setting, assaultive behavior, history of cruelty to animals; child's refusal to contract for services. Minor children will not be accepted for treatment without consent of parents or legal guardians.

ADMISSION CRITERIA (Child programs)

Based upon a review of intake materials as well as phone conversations with the placing family and hometown therapist, the child and the family appear to be appropriate for this treatment program. There is clear indication that attachment disorder is likely to be present and the family has the flexibility and resilience necessary to make adaptive changes.

PROCESS:

Pre-Placement Application:

- Reactive Attachment Disorder Questionnaire
- Achenbach (child Behavior Check List(s) by parent, teacher, child
- Psychosocial history
- "A Day in the Life of this Child" narrative by parent
- Parent(s) Autobiographical information
- Parent(s) Psychological Test Results
- Clinical Records
- School Records
- Social Service Records
- Psychiatric Records
- Family/Sibling Assessments
- Comprehensive Symptoms Profile
- Review of family history of psychiatric disorder

TREATMENT:

Attachment Therapy is a unique synthesis of many different techniques which are employed to facilitate the development of attachment between child and parent. These are rooted in an understanding of neurobiological factors, the function of memory, the effects of trauma, grief and loss, and the critical importance of attachment to the healthy development of a child. Treatment occurs within the context of a safe, nurturing, respectful environment.

TREATMENT PLANNING:

The therapist drives the process. The treatment plan drives the team. Placing parents and child are involved in treatment and treatment planning. The therapist may decide to include other individuals on the team dependent on the needs of the individual child and family. Others may include psychiatrist, offender assessment specialist, neurodevelopmental specialist, parent consultant, other significant individuals in the life of the child/family. ***All members of the team have the right and the responsibility to monitor the treatment process and to question and/or stop any process with which they are not comfortable.***

TREATMENT TECHNIQUES:

- Informed consent
- Contracting, with parents/guardians and child (in age appropriate terms)
- Cognitive restructuring

Role modeling
Behavioral shaping
EMDR
Emotional cathartic therapy
Psycho-educational therapy
Affect regulation (helping a child learn to go in and out of intense emotions and gaining the ability to regulate and to handle these emotions)
Cradling posture (as you would cradle and nurture an infant)
Parent/child bonding techniques
Psycho-drama
Guided imagery
Structural family therapy
Sibling therapy
Couples therapy
Existential psychotherapy
Legacy recognition and restructuring (re-decision therapy)
Gestalt therapy
Journaling
Paradoxical techniques
Taking a moral inventory
Making amends
Life scripting
Medication therapy
Neurodevelopmental and sound therapy
Motivational therapy (body training)
Sex offender treatment
Therapeutic foster care environment (milieu therapy)
Parent training
Therapist training

We do not utilize any therapeutic practice that puts a child's physical and psychological safety at risk. For this reason, we are opposed to the use of restraint as therapy, we are opposed to any practice that puts physical pressure on children or that causes a child physical pain, we are opposed to any practice that interferes with a child's life functions, or any which does not allow a clinician to monitor a child's vital signs at all times, we are opposed to any practices degrading to children.

SAFETY/RISK MANAGEMENT PLAN:

Our Continuous Quality Improvement Plan monitors such risk indicators as:
Critical Incident Reports
Compl aints/Grievances
Restraint Reports
Client Satisfaction Reports.
Our assessment process should identify potential risks with clients.

Our hiring practices should identify potential employee risks.
Our training and development plan for employees and contractors emphasizes training in the proper use of restraint, handling blood-borne pathogens, infectious disease control, etc.
Our research committee ensures that client rights are respected.
The treatment team is educated about their rights and responsibilities to question and/or to stop any process that causes them concern.
We actively pursue excellence and adhere to our own Code of Ethics and Board Policies.

PROGRAM EVALUATION/OUTCOME STUDIES:

For several years we have conducted several preliminary research studies. One doctoral research study was completed. Since that time we have conducted on-going research on the effectiveness of this treatment. We are interested in additional research projects that will help to further our ability to help children with this disorder and their families. Research indicates a 75 – 80% effectiveness rate in reducing delinquent and aggressive behavior and increasing pro-social behavior. Copies of these studies are available through our office. One study was Published in the Child Psychiatry and Human Development Journal, July, 1999.

THE TEAM

At IACD, a multi-disciplinary treatment team approach is used consisting of therapists, therapeutic foster parents, psychiatric consultant, clinical director, hometown therapist, placing parents and child. Each member of the treatment team plays a vital and distinct role. The success of this treatment is dependent, to a large extent, on each member of the team fulfilling their particular role within the context of the team. Their individual roles are defined more specifically by the treatment plan, which the team develops for each child and family that participates in treatment at IACD. We have contract and employee licensed therapists with specific training in the field of attachment.

**All clinicians carry their own private malpractice insurance in addition to general liability insurance coverage for the agency.

Employed Staff

Forrest Lien, LCSW, Director and Therapist
Heidi S. Wilmanns-Friese, MSW. CAPSW, Staff Therapist and Manager of Clinical Services

Konnie and Clayton Stoltz, Therapeutic Foster Parents
Jacqueline and Michial Owens, Therapeutic Foster Parents
Darlene and Jim Wright, Therapeutic Foster Parents
Katie Stoltz, Respite & Relief
Rose Smith-Receptionist / Administrative Assistant / Respite & Relief
Claire Szafraniec, Medial Records / Billings

Janice Travis-Finance and Bookeeping
Candy Porter, Facilitites Director

Contract Staff
John F. Alston, M.D. / Psychiatrist
Margaret Meinecke, LCSW, CACIII, Contract Therapist
Beverly Baker White, MA, LPC, contract Therapist

Please go to the website for more information at www.instituteforattachment.org

LICENSING/ACCREDITATION:

We are licensed by the State of Colorado as a Child Placement Agent

TWO-WEEK INTENSIVE TREATMENT PROGRAM

Many of the children referred to The Institute for Attachment & Child Development, Inc. ("IACD") for treatment initially undergo what is called a two-week intensive program of therapy. In this therapeutic approach the child, parents (and when appropriate, other family members), and a hometown therapist participate in at least thirty hours of daily therapy over a two-week period. This short-term, but intense, format provides an array of clinical advantages when treating highly resistant, controlling, non-trusting children. The consistency, continuousness, and focus of daily therapeutic contact create a context in which the child's defenses are reduced, his motivation is increased, and a trusting therapeutic relationship can be established. This therapy, however, was never intended to be a "magical cure" even though significant and dramatic changes often occur during the two-week experience. Confronting distorted thinking, in conjunction with nurturing and strong support, "opens the door" for conventional therapy to be more effective. No matter what gains are achieved in the two-week intensive, however, follow-up therapy is **essential,** in our experience. Another advantage of IACD's intensive therapy format is our ability to directly observe and modify family relationships and dynamics. Parent-child, marital and sibling issues become evident in these daily therapy sessions. We also encourage referring therapists to participate in the daily treatment process, whenever possible. This increases the likelihood of effective follow-up for the child and family, as well as providing training and supervision to mental health professionals interested in learning about this mental health problem.

ATTACHMENT DISORDER DESCRIPTION

IACD was started thirty-three years ago for the purpose of treating children with Attachment Disorder. Attachment Disorder results when there is a serious interruption of the bonding cycle during the early critical stages of life, from conception through the first 26 months. This may be due to a difficult pregnancy, maternal stress or trauma, separations from primary caretakers, sexual abuse, physical abuse, psychological abuse, neglect, maternal depression or other mental

illness, frequent change of caretakers, foster care, adoption, parents with inadequate parenting skills or unrelieved pain of the child due to chronic illness.

Children with Attachment Disorder do not learn to trust; they become oppositional, angry and often dangerous to themselves and others. They are unable to give and receive affection in a healthy way. They lack cause and effect thinking and frequently do not develop a conscience. For them, being in control of everyone and everything has become a survival technique. As a result, these children will not allow themselves to be parented. They suffer from one of the most difficult emotional and behavioral conditions. Unfortunately, society is seeing an increase in the number of children with Attachment Disorder. If left untreated, these children with Attachment Disorder have the potential for creating tremendous damage--for themselves, for others, and for society. Many will face a lifetime of incarceration. We are all affected by this unconscionable, but treatable, condition in some way.

SYMPTOMS:

- Inability to give and receive affection in a real way
- Lack of eye contact on parental terms
- Indiscriminate affection with strangers
- Marked control problems; extreme defiance and anger
- Destructive to self, others, animals, material things; accident-prone
- Manipulative, superficially “charming”
- Stealing
- Hoarding and gorging food
- Preoccupation with fire and gore
- Lack of impulse control and cause and effect thinking
- Learning and speech disorders
- Lack of conscience
- Lying about the obvious
- Poor peer relationships
- Persistent nonsense questions and incessant chatter
- Inappropriately demanding and clingy
- Parents appear hostile and angry

Most of these children have been through many different types of therapy which have proved to be ineffective for them. Most traditional therapy is based upon mutual trust and respect and the ability to form a therapeutic relationship. It also depends upon emotional honesty. These are not

qualities possessed by the Attachment Disordered child. In fact, these children have been described by others as “extremely poor candidates for therapy”.

THE THERAPY

At IACD, we would define the terms Attachment Therapy in the following manner. The term Attachment Therapy describes a wide range of therapeutic processes which may include inner child work, re-parenting, cognitive restructuring, holding, and psychodramas (role playing), among others. The goal is to help a child develop the capacity to trust and love, and by doing so, to live a happy and productive life. The term Holding Therapy may be an important part of Attachment Therapy. Holding Therapy involves the process of engaging in nurturing, non-restrictive holding to facilitate a positive connection between parents/therapist and the child, and to provide a safe environment for exploration of feelings and confrontation of behavior.

At IACD, holding of the child during therapy involves cradling the child in a non-restrictive manner as he sits being held across-the-lap of the parent or therapist. This therapeutic cradling is done in much the same way you would hold an infant in your arms. This type of interaction between the child and the parents or therapist helps facilitate many of the key components of bonding, such as eye contact, touch, movement, and smiles. The therapy provided at IACD has evolved over the years, as new therapeutic methods have proven successful. All therapy at IACD occurs within a safe and nurturing environment by skilled and competent therapists, and at no time is the child put in a position that would risk any type of physical harm.

During therapy, IACD uses highly trained therapeutic parents to help the child learn to live and love in a healthy family environment. Often, parents who bring their child into treatment are emotionally defended and wore out so placement in a therapeutic family is necessary for the child and family. The goals of treatment are to help children with Attachment Disorder, and their families, find more effective ways to meet their needs. Therapy occurs on multiple levels--cognitive, affective, behavioral, interpersonal and spiritual. Each child is unique. A thorough assessment of the child within his/her family forms the basis for an individual treatment plan. This assessment includes social history, psychological testing, medical assessment, family assessment, review of previous treatment, psychiatric evaluation, etc.

TREATMENT INVOLVES:

- Identification of feelings
- Validation of child’s feelings
- Encouragement of appropriate and safe expression of those feelings
- Education as to origin of feelings
- Resolution of early trauma through revisiting the circumstances, reframing the trauma, healing the trauma, empowering the child to grow beyond the trauma
- Working through grief and loss issues
- Cognitive restructuring of faulty thinking patterns, attitudes, and perceptions
- Increasing child’s self control abilities
- Reshaping behavior to more appropriate and socially acceptable levels

- Enhancing a child's self esteem
- Helping child to develop positive sense of identity
- Improving social interaction patterns by focusing on respect for others and reciprocity in relationships
- Helping child to develop thoughtful decision-making skills
- Helping child to accept responsibility for his/her own behavior
- Helping child to develop the capacity for joyful play
- Helping child to experience and accept loving, nurturing care
- Helping parents learn effective parenting techniques that shape behavior while nurturing the child
- Helping parents identify and alter negative parent-child interaction patterns
- Helping parents resolve their own issues of grief and loss

Although this therapy is sometimes intense, it is always sensitive to the child and to the family. Both the child and the family are respected and cared for. Self-defeating behaviors are confronted. Individuals are asked to work very hard to face the difficult issues which perpetuate these self-defeating behaviors. Confrontation and intensity are important parts of the therapeutic process, but the process includes so much more. **The therapeutic process experienced through The Institute for Attachment & Child Development, Inc., is loving, nurturing, respectful, empowering and effective. No harmful or potentially harmful techniques are utilized.** We find this treatment to be highly effective when used by trained professionals in a clinical setting with specific children.

THERAPEUTIC PARENTING

Therapeutic parenting is an approach to treating children and training parents of children with severe emotional disorders. The therapeutic parent is a highly skilled and trained individual who works in conjunction with the treatment team to treat the child in the therapeutic milieu of a family. The expertise and involvement of the therapeutic parent are the foundation of this unique approach. The therapeutic parent creates a therapeutic environment in which the team treatment plan is implemented on a 24-hour basis.

During the two-week intensive, the child usually stays with a therapeutic family. The parents have the opportunity to stay at IACD's charming and historic lodge called William's House for a reduced rate of $55 a night for each room used. Alternatively, parents can stay at a nearby motel and come to IACD every day for treatment sessions. The child usually does not stay with his parents. Instead the child receives 24 hours per day therapeutic care at the treatment home of the therapeutic foster parents. Parenting techniques that have been found to work for children with attachment disorder are used in the treatment home and throughout the two week intensive are taught to the placing parents. The placing parents spend time in the therapeutic home observing and learning the new parenting techniques. The placing parents thereafter take the child on "practice visits" to their lodgings, local restaurants and other appropriate places to practice using these new techniques with their child. These newly learned parenting techniques teach the child to think through and make appropriate choices, to accept responsibility for their actions, and to develop an "inner voice" (conscience). These newly learned techniques allow the placing parents

to be empathic in dealing with the child, but at the same time allow the child to learn from his/her own experiences. As the child learns to trust and love, the child's beliefs change. The child no longer believes that he/she is worthless and the world is hostile. Instead, the child's now believes that he/she is worthwhile and capable and the world can help him/her to grow.

FOLLOW-UP TREATMENT:

Once the two-week intensive is completed, the work continues. On the last day of the two-week intensive therapy a follow-up treatment contract is written and signed by all team members. This contract is agreed to by all parties involved in the future care of the child and specifies what will be done by all parties contributing to the continued care of the child. It includes specific time frames, goals and measurements as well as contingency plans. This follow-up treatment plan is the springboard for the child who is beginning a new life. Good communication between IACD's clinical team, the hometown therapist, the therapeutic family and the placing family is imperative. The team effort allows for the exchange of a variety of ideas. It also provides for the continuity of care with the follow-up therapist.

Most of the time, the placing family departs from IACD with a sense of enthusiasm. This enthusiasm, however, is also accompanied by feelings of inadequacy and fear of failure. Parenting skills learned in treatment seem rough and unnatural at first. It often takes time and practice for the placing parents to incorporate these new techniques into the family life style with a sense of ease. To help the family adjust to and maintain these new ways of interacting, a member of the treatment team keeps weekly contact with the family during the first month following treatment.

During the two-week intensive, the child has gained structured guidelines for behavior and has experienced specific exercises to foster trust and reciprocity within relationships. The child has been emotionally open to the possibility of warmth and love. After the initial two-week intensive is completed, however, therapy must be maintained and follow-up services provided or there is little chance of lasting success. Even with a well-structured post intensive follow up plan, the child can be expected to occasionally revert to old patterns of behavior. When this happens everyone must be ready to address this back sliding by the child. This is a time that tests the resolve, commitment and creativity of everyone. It is a dangerous time in the relationship between the child and his family. But with a good follow-up plan, team support, good communication, and strong parenting techniques, this difficult stage can be positively addressed.

Important to success is the personal and marital strength of the placing parents. They are encouraged to improve communication styles and develop ways to minimize stress while learning to re-parent and nurture their child. Attachment therapists instruct placing parents that the number one rule in effective parenting is to take care of themselves. On-going therapy to resolve personal issues that impact parenting is often recommended for the parents. During the treatment sessions, parents learn to reinforce reciprocity, foster responsible behavior, and maintain structure with their children.

For the child, the true test of the ideal reciprocal behaviors and regard for others is out in the "real world" of challenges and choices. When returning home after the two-week intensive, if parents are able to regularly and consistently employ tools learned in treatment, the child's chances of trusting others enough to apply reciprocal behaviors and attitudes are dramatically improved. Approximately 6 - 8 weeks following the two week intensive, the therapeutic parent will visit the home to provide additional support and training.

IACD maintains “formal” contact with the family for at least TWO MONTHS following treatment at IACD. In truth, numerous families and children maintain contact with members of IACD’s staff for many years after treatment. During that year following treatment, behavior checklists regarding the child are filled out by the placing parents and reviewed by the treatment team. This forms the basis for on going suggestions and support.

EXTENDED TREATMENT PROGRAM & THERAPEUTIC FOSTER CARE

PROGRAM OVERVIEW: This program is designed to provide comprehensive and extended treatment to children who have completed the two week intensive treatment program, but who need additional time to correct negative interaction patterns between child and parents, or who need more time to incorporate new behaviors into family living style. The program provides a therapeutic parenting milieu, on-going therapy, medication reviews, quarterly clinical reviews, and appropriate ancillary services.

ADULT TREATMENT

- Healthy attachment behavior is critical in order for any relationship to survive. Children that suffer from early abuse, neglect, loss of a parent because of death or divorce, emotionally distant parents, or shaming parents struggle in their adult relationships.

  Attachment difficulties are on a continuum of disturbance that range from attachment issues all the way to attachment disorder. Typical adult diagnoses for adults who suffer from attachment difficulties might be borderline personality, histrionic personality, antisocial personality, narcissistic personality, dependent personality, obsessive-compulsive disorder, and other DSM Diagnoses in the Axis II category. Attachment difficulties present as a condition in which individuals have trouble forming loving, lasting intimate relationships. Attachment disorders vary in severity, but the term attachment disorder usually is reserved for individuals who show a nearly complete lack of ability to be genuinely affectionate with others. These people typically fail to develop a normal conscience and do not learn to trust.

Distortions in Thinking

As children, our brains organize relative to the environment in which we grow up - either safe and secure or scary and sad. Our feelings are stored in the limbic system or midbrain. On the other hand, our right orbitofrontal cortex performs abstract reasoning. One of the most common adaptive behaviors in which humans engage is “pain avoidance”. Thus, a child who grows up in a maladaptive environment (painful environment) organizes his brain in a maladaptive style that involves emphasizing survival behaviors rather than feelings of security and love. This organization of the brain results in intelligent adults with a maladaptive upbringing to have a tendency to function more from a reasoning place of denial of feelings (which is a function of the orbitofrontal cortex) rather than integrating the limbic system feelings into appropriate responses. In these adults with maladaptive upbringing, when the emotions residing in the limbic system are triggered, the frontal lobe jumps to attention with a strategy to defend or deny those feelings rather than integrate the limbic system feelings with their cognitive response. The two most

common feelings triggered in these adults tend to be fear and sadness. Once these feelings are triggered, their defenses go into action to protect them from those feelings. Adults with attachment difficulties want to be loved and accepted but don't have the "tools" to achieve that goal. Their cognitive distortions sabotage what they want and need. This is why traditional therapy usually does not work for these adults. In traditional therapy, the adult client with maladaptive upbringing usually functions more from his frontal lobe. This is because talk therapy tends to be more of a cognitive process for them. They never access and deal with their limbic-stored emotions. The more intelligent the client, the better they are at defending their stored up feelings of inadequacy. As a result, they tend to get frustrated by traditional therapy and don't believe that it helps.

OTHER CLINICAL PROGRAM DESCRIPTIONS CAN BE ACCESSED VIA OUR WEBSITE AT WWW.INSTITUTEFORATTACHMENT.ORG

Contact Us

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For comments about the web site, or to report a problem, please email the Webmaster.

Revised 08-5-2005