Reactive Attachment Disorder

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Abstract

From the first to our last moments of life we are designed to have a crucial bond of love with another human being. This begins with our primary caregiver, usually our mother and father, and extends as we grow into adulthood. When attachment is disrupted by maltreatment children and their caregivers are faced with overwhelming difficulties as they navigate through life. This paper and accompanying presentation will discuss Reactive Attachment Disorder, presenting behaviors of Reactive Attachment Disorder, obstacles mental health professionals face, treatment modalities, and community support for children and their caregivers. A brief summary of similarities between Individual Psychology and Attachment Theory will conclude this paper.
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Project Introduction

This project was designed to bring awareness to new clinicians about Reactive Attachment Disorder (RAD) and the difficulties these children, adolescents and their primary caregivers face along with possible treatment modalities. In my experience I have heard the term RAD used without a functional understanding of how it develops and presents in children and adolescents. There are classes offered that briefly covers RAD. My intention is to bring a richer understanding of the literature and my personal experiences while working in a specialized attachment clinic for my internship hour. Thousands of children each year are diagnoses with RAD and a common problem found in research is that child clinicians seem to have a misunderstanding which may lead to misdiagnosis or over diagnosis.

The target population was for this project was fellow classmates at the Adler Graduate School. While taking my internship courses at Adler, I would share my experiences at the Family Attachment and Counseling Center and realized many of my classmates lacked exposure and an understanding to RAD symptoms. There was also a lack of understanding surrounding the struggles adoptive parents faced. The cases I worked with were families that adopted internationally and all of the children/adolescents came from an orphanage setting. Along with a lack of understanding of RAD I also witnessed several of my classmates lacking exposure to Play Therapy, Filial Therapy and Dialectical Behavioral Therapy.

My goal was for attendees would leave with a better understanding of what may be presented to them in the mental health field. This project also assists attendees’ with a
deeper understanding of treatment modalities that may assist children and their families that face difficulties with attachment.
Reactive Attachment Disorder

The purpose of this project is to provide mental health professionals with a basic understanding of Reactive Attachment Disorder (RAD) and its impact on children and families. The term RAD is often talked about with a lack of understanding of how the disorder develops and presents in children. Every year thousands of children are diagnosed with Reactive Attachment Disorder. This paper will define and explore the behaviors associated with RAD, obstacles mental health professionals face in understanding general diagnosis, treatment modalities and community support for children and their primary caregivers.

**Definition of Reactive Attachment Disorder**

The quality of care during the first months and years of life has important implications for a child's development. A baby is completely dependent on a caregiver to fulfill the basic needs of food, comfort and safety. Nurturing fulfillment promotes optimal development and facilitates a secure attachment relationship between caregiver and child. However, maltreatment such as abuse or neglect may compromise development and cause social, cognitive, emotional and behavioral problems as the child grows. Children who experienced maltreatment early in life may suffer from a condition called attachment disorder (Nichols, Lacher, & May, 2010). Attachment disorder may impact the way one views themselves and future relationships.

Reactive Attachment Disorder otherwise known as (RAD) is a mental health disorder in which a child is unable to form healthy relationships, particularly with his or her primary caregiver. Attachment is a term used as a strong emotional bond that develops between children and their caregivers. Reactive Attachment Disorder is commonly seen with children who have experienced a form of trauma before the age of 5. It is thought to result from a lack of consistent care and nurturing in early years. Most children with RAD have had severe problems or
disruptions in their early relationships. Many children with RAD have been physically or emotionally abused or neglected. Some have experienced inadequate care in an institutional setting or other out-of-home placement such as residential programs, foster care or orphanages. Some children with RAD have had multiple or traumatic losses in their primary caregiver.

When an infant is separated from their primary caregiver he or she exhibits attachment behaviors such as crying, clinging or searching, in order to try to prevent the parent from leaving or to communicate that they need them back. Even as adults, we adhere to some level of proximity maintenance with our loved ones. Distance and separation create feelings of threat and fear, causing anxiety and anger initially, and sadness and despair over time (Cassidy, 2008).

RAD is characterized by the inability of a child or infant to establish age appropriate social contact and relationships with others. Symptoms of the disorder may include a failure to thrive, developmental delays, a refusal to make eye contact, feeding difficulties, hyper-sensitivity to sound and/or touch failure to initiate or respond to social interactions with others, self-stimulation, indiscriminate sociability and an unusually high susceptibility to infection (American Academy of Child and Adolescent Psychiatry, 2011).

**Diagnostic Criteria for Reactive Attachment Disorder**

According to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000), RAD is a disorder caused by a lack of attachment to any specific caregiver at an early age, and it results in the inability of the child to form normal, loving relationships with others.

There are two types of presentations. The Inhibited Type is characterized by a predominant failure to initiate and respond to most social interactions in a developmentally appropriate way for their age. Many of these children appear to be hypervigilant or have
ambivalent responses (resistance to comfort, frozen watchfulness, or a mixture of approach and avoidance). In moments of distress or anxiety, when young children would typically seek comfort in their caregivers, children with inhibited type RAD display an emotionally and socially withdrawn pattern when interacting with others. They either do not seek comfort or are afraid to seek comfort, and when comfort is offered they fail to respond or actively resist. Additional, responses to comfort found children with inhibited type RAD can be (but are not limited to) anger, aggression, sudden outbursts, vigilance, defiant behavior, crying, sulking, awkwardness in social situations and irritability (Hardy, 2007).

The Disinhibited Type is characterized by a pattern of diffuse attachment. The child shows indiscriminate sociability or lack of selectivity in their choice of attachment figures. These children fail to discriminate attachment figures and may approach unfamiliar adults without reservation seeking or receiving comfort from them. Children with Disinhibited type RAD can present (but are not limited to) very demanding, attention seeking, exaggeration of needs for assistance, chronic anxious appearance, and can be perceived as shallow. These children have a higher risk to go off with strangers, because they fail to distinguish between people that want to help or harm (Hardy, 2007).

Currently there is no specific, validated tool for diagnosing Reactive Attachment Disorder. Diagnosis is made on the basis of a diagnostic interview, history and behavioral observation. Medical and psychiatric examinations of symptomatic children are appropriate to rule out physical causes or differential mental illness diagnoses which might account for children's withdrawal, ambivalence or social promiscuity. It is also important to interview the child’s primary caregiver in order to obtain history of maltreatment and attachment disordered behaviors (Boekamp, 2008). It is important to distinguish RAD from other diagnoses with
related symptoms because effective treatment for RAD and these other disorders can be quite different.

For example, some children with RAD and many children with Conduct Disorder exhibit aggressive behavior, have frequent temper outburst, and are often rejected by peers and adults (Alston, 2000; Wilson, 2001). However, children with RAD have a pervasive inability to form developmentally appropriate relationships with others, whereas most children with Conduct Disorder are able to form some satisfying relationships with adults (Hauggard & Hazan, 2001).

Children with inhibited type of RAD are often withdrawn in the same way that depressed children are withdrawn. Depressed children are often able to form appropriate social relationships with those who reach out to them, whereas children with Reactive Attachment Disorder seldom have the ability (Alston, 2000).

A primary obstacle in recognizing RAD is a general lack of familiarity with the disorder by child clinicians. RAD is a relatively new diagnosis and may be misunderstood by many clinicians (Alston, 2000; Wilson, 2001). As noted above, RAD shares many symptoms with disorders that are common among children, including depression, and conduct disorder. Clinicians having a greater familiarity with other child disorders may result in children being misdiagnosed. Due to some very broad but untested diagnostic checklists, Reactive Attachment Disorder may easily be over-diagnosed. The connection between attachment insecurity and other non-attachment–specific disorders is also far from clear, and the existence of co-occurring disorders is likely to increase the complexity required for effective treatment (Hardy, 2007).

To assist children who have experienced a form of complex trauma there are community based agencies such as Anne Gearly’s Developmental Repair Model at Washburn Center for Children. Behaviors are coming to community attention at increasingly early ages. These very
high risk children are identified through child welfare, in early education and day care, at entry to kindergarten, in schools and in mental health centers. Many children have already been excluded from school, day care and other settings. Their older counterparts disrupt schools and terrorize neighborhoods, despite community efforts to alter this developmental trajectory towards increasing violence and social estrangement. To label these young children as behaviorally deviant overlooks children’s desperate efforts to survive endangering experiences. Their histories of early risk experiences cause them to feel—and act—out of control.

School represents a second opportunity for social and emotional learning. For most children, school builds on what they have learned with their families. For these very-at risk children, coming into school or community is where their difficulties really stand out. They want to learn, but quickly fail because they lack early pre-learning skills as well as early academic and self care skills. They struggle to explain their needs or experiences with words instead of behaviors. They often confuse or alienate teachers who try to engage with them. They come to school not knowing how to be taught, or how to be helped. These children become increasingly isolated when they oppose rules or engage in power struggles. Many resort to behaviors that further exacerbate their social disconnection (lying, stealing, harming property, and harming others). These behaviors make early onset delinquency a likely probability. Everyone becomes preoccupied with changing their behaviors. Some very at risk children have talents such as athletic abilities or artistic skills, but these skills are not nurtured when children are disruptive (Geadness, 2009).

Developmental Repair shifts how these children are perceived. Instead of assuming that these children intend to be aggressive or disruptive, clinicians see how their early development
has been compromised by persistent trauma and relational stress. Children’s behaviors reveal their efforts to cope with too few resources, including too little adult protection (Gearity, 2009).

**Treatment Modalities for Children and their Caregivers**

There are two common approaches in treating children and their primary caregivers with attachment problems. The first is psycho educational treatment focused on increasing parental knowledge of child development, self-care and relationship building. The other is psychotherapy with the parent and child, focusing specifically on the attachment relationship and dysfunctional internal representation. Cornell and Hamrin (2008) state that psycho education in treating children with attachment disorders can involve both the parent and child or the parent alone. It is also recommended that the clinician take on the role of coach to the parent, not modeling but simply teaching practical information then helping the parent implement it. Loving and capable caregivers provide the core of what is needed to help children with RAD to begin their recovery. It is not necessary that the family be biologically related to the child. What is necessary for affected children to recover is that they are no longer neglected or abused, and are instead offered plentiful opportunities for loving interaction.

Although being in the presence of a loving family may not be enough to help some children with more severe RAD. Such children may persist in their inhibited or disinhibited behavior despite their family's best efforts. In such cases, professional treatment is necessary. There is no singularly useful therapy for helping children with RAD recover. Instead, a combination of therapy approaches may be recommended (Barkoukis, Staats Reiss, & Dombeck, 2008).

For years play therapy has been a well-established and popular mode of child treatment in clinical practice. Hall, Kaduson, and Schaefer (2002) in the article Fifteen Effective Play
Therapy Techniques state: “One reason play therapy has proven to be a particularly useful approach with children, is that they have not yet developed abstract reasoning abilities and verbal skills needed to adequately articulate their feelings, thoughts, and behavior. For children, toys are their words and play is their conversation” (p. 515).

Play Therapy is a method of psychotherapy with children in which a therapist uses a child's fantasies and the symbolic meanings of his or her play as a medium for understanding and communication with the child. Reaching children through play is entering a child's world, relating to the child's unique perspective, and forming safe and empowering relationships with honor and respect for the child. The honoring process entails being present, accepting, respecting and validating a child's emotions and behaviors, giving meaning and value to everything the child says and does in the play session (Norton & Norton, 1997).

The objective surrounding Play Therapy is to decrease the behavioral and emotional disturbances that interfere with the child’s standard functioning. It is also used to enhance communication and understanding between the child and their caregiver. Additional goals surrounding Play Therapy are improved verbal expression, ability for self-observation, improved impulse control, adaptive ways of coping with anxiety and frustration, improved capacity to trust and relate to others. Play therapy allows the clinician an understanding of the child’s inner working model and an understanding of cognitive and emotional development. This form of therapy is commonly used with children that have experienced complex trauma (Norton & Norton, 1997).

In play therapy, the clinician meets with the child alone for the majority of the sessions and arranges times to meet with parents separately or with the child, depending on the situation. The structure of the sessions is maintained in a consistent manner in order to provide a feeling of
safety and stability for the child and parents. The session length will vary depending on the environment. For example, in private settings, sessions usually last 45 to 50 minutes while in hospitals and mental health clinics the duration is typically 30 minutes. The number of sessions and duration of treatment varies according to treatment objectives of the child. Children communicate their thoughts and feelings through play more naturally than they do through verbal communication. As the child plays, the therapist begins to recognize themes and patterns or ways of using the materials that are important to the child. Over time, the clinician helps the child begin to make meaning out of the play. This is important because the play reflects issues that are important to the child and typically relevant to their difficulties (Chethik, 2000).

When the child's symptoms have subsided for a stable period of time and when functioning is adequate with peers and adults at home, in school, and in extracurricular activities, the focus of treatment will shift away from problems and onto the process of saying goodbye. This last stage is known as the termination phase of treatment and it is reflective of the ongoing change and loss that human beings experience throughout their lives (Chethik, 2000).

In addition to Play Therapy a similar intervention that may be introduced to the primary caregiver this is called Filial Therapy. Filial Therapy is an approach in which caregivers are included together with their children in the process of learning and changing. In essence, parents learn how to conduct client-centered play therapy sessions with their own children and then proceed to have weekly home play therapy sessions with them. Parents are taught a variety of basic skills, such as reflective responding, limit-setting and choice-giving (Wickstrom, 2012). Filial Therapy addresses the emotional needs of children in the same way as nondirective play therapy but uses one or both parents/caregivers as the therapeutic agents of change (Ryan & Courtney, 2009). When the entire family feels included in the process, participation brings
cohesiveness to the family as a whole. Filial therapy creates a shift in the traditional role of the clinician from the focus on dysfunction to one of helping the parents be effective with their own children. This shifts the nature of the relationship system between clinician and family to one of learning and collaboration. Bringing both parents together with their children to work on this learning experience, as well as implementing what they’ve learned can be significant in enhancing the marital relationship. The strengthening of their relationship only further enhances the stability and continuity of the family.

Families organize themselves to have weekly play sessions that are conducted at a consistent time every week begin to develop a rhythm that enhances family life. It is important to emphasize that the filial therapy process can be as difficult as any clinical intervention. Good results rely greatly on the skills and experience of the clinician (Ginsberg, 1991).

Developmental Repair is an intervention program designed here in Minnesota by Anne Gearity and her team at Washburn Center for Children. The program has been implemented for very high risk youth (ages 3 to 3rd grade) who need intensive early intervention because their aggressive and disruptive behavior is harming themselves and others, and they have not been able to benefit from usual community resources. Unlike most children, even those with less severe behavioral problems, these at risk children are unable to make this developmental transition from home to larger community participation.

These at risk children need intensive and sensitive intervention to alter a maladaptive trajectory towards conduct disorders. They need repair of core developmental capacities that permit more positive adaptation. This intervention must be relational because this developmental learning always relies on interpersonal experiences with care giving adults. Interventions help children acquire developmental skills that are normal for their age, such as self-regulation. And
directly address children’s social alienation, lest they become further disconnected from their peers and the larger community (Gearity, 2009).

Providing new relationships that the child can depend upon for developmental support does not replace families. Developmental Repair helps parents attend to their children’s immediate developmental needs. However, because many of the parents have had histories similar to their children, they often have similar vulnerabilities. Intervention scaffolds their parenting efforts with encouragement and tangible explanations about interacting in new ways with their children. Intervention works to repair this relationship. When children can function better within their families, and their communities, they contribute to change within the family by reducing parental stress. Ameliorating children’s behavioral difficulties in the larger community also relieves a significant social stress for their families. Parents may then generalize their increasing effectiveness to other parts of their lives (Gearity, 2009).

Family Attachment Narrative Therapy was developed to heal the experience of early child maltreatment. Unresolved childhood trauma has been correlated with impaired and delayed cognitive, behavioral and emotional functioning. Gentle, soothing, non-provocative and nonintrusive narratives told by the parents provide an alternative restorative experience designed to shift and change the child’s destructive internal working model. The result is improved functioning and the ability to accept nurturing and care in relationships that offer love and safety (May, 2005).

Family Attachment Narrative Therapy is guided by the belief that parents are the primary healing agents for children, and builds on parent knowledge about the child's internal motivations. This approach is gentle and nonintrusive, yet intensive and powerful. Therapists at the Family Attachment and Counseling Center train parents to create narratives that increase
feelings of security, address issues in the child's history and help the child reach new conclusions about his or her life experiences. With the necessary support, parents are able to attune to their child and provide the sensitive, caring experiences missed in their early years. This helps the child take a new perspective on life and provides a pathway for an improved future. Parents, along with the therapists, create four types of attachment narratives, unique to the child. Families start with claiming narratives that are used to communicate the message that from the beginning the child deserved love and care. This is also used to impart family traditions and history. Next are the developmental narratives that are designed to help the child to progress properly through necessary stages of development. Trauma narratives follow and address trauma history that helps the child gain a new understanding of life events. Caregivers finish the intensive sessions with successful child narratives that teach children positive core standards for behavior (Nichols, Lacher, & May, 2010).

The Family Attachment and Counseling Center located in Deephaven, Minnesota has proven success of this methodology. Changing the child's negative inner working model is frequently demonstrated by the child's report once they have completed several intensive sessions with their caregiver. Based on parent/caregiver report and clinical observation, most of the children demonstrate vastly improved attachment to their parents. The reciprocal loving relationship, longed for by parents, is regularly evidenced by the child’s initiated, spontaneous hugs and expressions of love (Nichols, Lacher, & May, 2010).

Another approach that may be useful in assisting adolescents and caregivers struggling with attachment difficulties and RAD is Dialectical Behavioral Therapy (DBT). DBT combines cognitive and behavioral therapy, incorporating methodologies from various practices including Eastern mindfulness techniques. Marsha Linehan, the founder of Dialectical Behavior Therapy
explains that she originally designed DBT in 1993, to address the needs of clients for whom the models in use at the time were insignificant (Linehan, 1993). More recently DBT has been demonstrated to be effective with other clinical presentations, both in research protocols and with anecdotal evidence (Moonshine, 2008). DBT is based on the theory that clients have internal distress. DBT skill sets are applied in everyday life to prevent emotional distress and dysregulation. The four main skills are Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness.

In the Upgrade your brain article Spydye, addresses how individuals routinely think about things that make them feel mad or wounded. By ruminating on negative experiences we are sensitizing and strengthening the amygdale (which is primed for negative experiences). By contrast, meditative and mindful practices stimulate the anterior cingulated cortex, the part of the brain’s outermost layer that controls attention (this is how mediation can lead to mindfulness). Deciding to be mindful can alter your brain so that being mindful is easier and more natural (Spadye, 2010).

DBT teaches clients how to use mindfulness practices and assists the client in learning to be in the here and now. Mindfulness is also about manifesting awareness, staying present in the moment on both the inside and outside to minimize interpretations, assumptions, abstractions and judgments. With DBT’s mindfulness skills clients learn to be nonjudgmental toward themselves and others. Yes, real change is possible. The emerging discipline of behaviorism taught that people could learn new behaviors, and that acting differently can in time alter underlying emotions from the top down (Carey, 2011).

There are two major philosophical points to DBT, listed are the following points: 1.) Clients are doing the best they can and need better skills to be more effective 2.) Clients have not
caused all their problems but they have to solve them anyway (Moonshine, 2008). DBT skills provide mental space for compassion, validation, growth and understanding. Adolescents and caregivers experiencing difficulties with RAD and attachment can use these techniques to keep them in the present moment, with a non-judge mental stance on pertaining to their future. These skills can also be applied to adolescents with RAD that are suffering from ruminating thoughts of their past trauma. DBT can be applied in individual sessions by a trained clinician and are also offered throughout the community in group settings for adults.

These various possible treatments for RAD focus on enhancing the child's appropriate attachment relationships, discouraging inappropriate/unsafe attachment behavior, helping to promote harmonious relationships within the family as a whole, and increasing the child's available social supports. The goal of these interventions is to encourage the child to develop trust in the possibility of consistent loving and safe relationships; an outcome that vastly increases their ability to develop appropriate peer relationships and to participate in the adult social world they will one day inhabit.

**Similarities between Individual Psychology and Attachment Theory**

Attachment Theory and Individual Psychology share several basic constructs. Social interest and attachment motive emphasize innate interactions with caregivers. The degree to which an individual’s needs are met in early relationships affects their level of social interest and ability to complete life’s task. Both Individual Psychology and Attachment Theory emphasize the innate necessity for relationships and social interaction that enables humans to contribute to exist and evolve (Weber, 2003).

Both Individual Psychology and Attachment Theory are built upon the theoretical premise of the importance of social interactions. According to Attachment Theory, species must
work together in order to exist (Bretherton, 1992). In Individual Psychology the individual and society cannot be separated (Ferguson, 2000). Both theories support the premise that the existence of one necessitates the existence of the other. Individual Psychology asserts that during infancy, children are inferior and helpless, and seeking nurturance from others enables them to provide for their needs. A healthy child requires a healthy community, shared responsibility and respect are necessary for long-term health. The welfare of the individual and the welfare of the group coincide. According to Attachment Theory, proximity seeking behavior is also necessary for the survival of the species (Ainsworth & Bowlby, 1991; Bretherton, 1992).

Both Individual Psychology and Attachment Theory support proximity seeking attachments as a foundation to social development. Individual Psychology and Attachment Theory believe in the importance of early childhood experiences and emphasize the importance of the family of origin or family atmosphere in forming personal constructs. Both theories emphasize the importance of the past on current development. Individual Psychology uses early recollections and lifestyle interviews, and Attachment Theory explores memories and representational models of past to facilitate understanding of the present (Searle & Meara, 1999). While there are many differences between the two theories the similarities are striking. Both theoretical positions can be termed cognitive, ecological, psychodynamic and systemic (Ainsworth & Bowly, 1991).

**Conclusion**

Attachment is a powerful concept concerning the emotional intensity and survival needs that affects every human being. As Alfred Adler taught, we show our level of mental health when our social, work and love lives are examined. Children who have experienced a form of complex trauma form their private logic at an early age and struggle to be understood. There are
several different treatment modalities and community support programs available to children and their caregivers. As with many mental health disorders treatment has numerous factors to be successful and is modified dependent upon circumstances. Additionally, Alfred Adler taught the importance of encouragement. With increased awareness of RAD mental health clinicians across the board will find a better understanding of the misrepresentation of these children’s behaviors and may incorporate more encouragement to children and their families facing attachment issues and behaviors associated with RAD.
References


