Reactive Attachment Disorder (RAD) Clinical Guidelines

Developed in collaboration with the mental health centers associated with NBHP and FBHP

DSM-IV-TR Diagnostic Code: 313.89

Diagnostic Considerations:

1. **Ensure diagnostic accuracy.** RAD is a rare diagnosis (< 1%), and behaviors may be better accounted for with other diagnoses. Research demonstrates that in reasonably responsive caregiving environments, children generally develop at least one healthy attachment. RAD has never been reported in the absence of serious neglect. Diagnosis requires the following: 1) disturbed and developmentally inappropriate social relationships before age 5; 2) failure of the child to respond to or initiate social interactions, or inappropriate friendliness with strangers; and 3) failure of early caregivers to meet emotional needs for comfort and affection, attend to the child's physical needs, or repeated changes in primary caregiver (pathogenic care before age 5). Some children have signs and symptoms of one type, many children have both.

   Two subtypes include:

   - **Inhibited:** 1) resisting affection and comfort from caregivers; 2) avoiding both physical and eye contact; 3) preferring to play alone; and 4) appearing to be on guard or wary.
   - **Disinhibited:** may demonstrate inappropriate and indiscriminant attachment behavior to virtually everyone, including strangers. Symptoms vary according to age and developmental stage and may include: 1) readily going to strangers, rather than showing stranger anxiety; 2) exaggerating needs for help doing tasks; 3) inappropriately childish behavior; and 4) appearing anxious or unable to focus.

2. **Thorough clinical assessment** by an experienced evaluator includes observation of child and caregiver interactions in numerous contexts, review of attachment behaviors with caregivers, careful developmental history (including placement and legal history), and observations of the child's behavior with unfamiliar adults. An assessment of abuse and/or neglect or maltreatment should be conducted. In addition to broad behavioral measures, such as the Child Behavior Checklist (CBCL) or Behavioral Assessment Scale for Children (BASC), the following semi-structured interviews may be useful: Disturbances of Attachment Interview (DAI) for young children under 5; Child Attachment Interview (CAI) for middle childhood and adolescence; Adult Attachment Interview (AAI) for older adolescents and adults; and the Preschool Age Psychiatric Assessment (PAPA).

3. **Healthy attachment** occurs when, between birth and three years old, a child is consistently responded to in a caring, sensitive, and attentive way. The child develops a sense of safety and security knowing that others are available and supportive. Children with healthy attachments learn they are worthy of love, have positive expectations about relationships, demonstrate reciprocity in relationships, display a range of emotions and appropriate levels of eye contact and comfort seeking behaviors. Attachment is a spectrum. While some children might display mild, or even moderate, attachment problems, this does not mean that full criteria for a RAD diagnosis is met.

4. **Review medical history and current health status**. Children who experience extreme neglect may show signs of growth delay, physical abuse, malnutrition, vitamin deficiencies, or infectious diseases. Encourage annual visits with primary care provider, and coordinate care as appropriate.

5. **Differential diagnosis** should include mental retardation, autistic disorder and other pervasive developmental disorders, language disorders, and posttraumatic stress disorder. There are a range of disruptions in attachment that do not necessarily lead to developing RAD, though maltreatment, relational trauma, or loss of an attachment figure increase the risk of developing other mental health disorders, such as PTSD, disruptive behavior disorders, depressive and anxiety disorders. These can also co-occur with RAD.

6. **Risk factors and protective factors**. Secure attachment (children seeking closeness and contact from caregiver when distressed and finding comfort in such contact) serves a protective function whereas

disorganized attachment (mixture of approach and avoidance with caregiver, unable to be comforted) is a risk factor, though insufficient in itself for diagnosis of RAD. Severe neglect during early childhood, and long term institutional care are risk factors. Even in these extreme situations, however, the rates of RAD for children raised in institutional settings and/or with severe neglect, is only 15%. The presence of one or more consistent, responsive caregiver is protective, even in institutional settings or frequently disrupted foster care placements. Little is known about the long term course of RAD. Prognosis is variable based on level of environmental support. However, even with the development of attachments later in life, indiscriminate sociability may persist.

7. **Consider cultural factors** during assessment that may influence behavioral norms such as acceptable amount of eye contact, interpersonal space, parenting values, etc. For children adopted cross culturally, also consider adaptive challenges when coming from orphanages in other countries, and how behaviors that appear dysfunctional may have served an adaptive function in that environment.

Treatment Guidelines:

1. **Treatment providers** should have adequate training for the treatment of RAD, in particular child development. Seek supervision, consultation, or additional training if needed before beginning treatment. Be aware of community supports and additional resources or referrals to support the client and family.

2. **The primary goal** of treatment is to strengthen the relationship between the child and primary caregivers. Working with families to develop or maintain a safe and stable living environment in which the child can explore trusting relationships is key. In foster care or adoptive placements, collaborate with social services and advocate for an emotionally available attachment figure. Support caregivers in providing a stable environment.

3. **Parenting skills** can facilitate developing attachment. Work with the primary caregiver by educating about distinguishing typical child development from symptoms of RAD. Help parents read the verbal and non-verbal cues of the child and attune to the child's needs (physical and emotional) even when expressed indirectly. Processing trauma and feeling intimacy creates fear responses from children with RAD, and fear responses can look like aggressive behaviors, hoarding food and objects, or running away. The caregiver's messages of unconditional love allow the child to feel safe enough to process trauma and feel intimacy. Key parenting tasks include teaching children how to identify emotions, develop empathy, and consistency in support, caring, and reinforcement patterns. Discussion around how caregivers can effectively handle rejection from the child (common in children with RAD) is helpful in maintaining stable placements.

4. **Family therapy**, that involves the child and caregiver working together to create positive interactions, is one of the most important factors for treatment success. Two models of effective dyadic interactive therapy for young children, which have been effective in cases of disturbed attachment, are Infant-Parent psychotherapy and Interaction Guidance. Evidence suggests the most effective interventions include similar components to effective child interventions in general, including: focused, goal-directed, behavioral approaches targeted at increasing sensitive parental behaviors and including fathers as well as mothers in the intervention. Parent Child Interaction Therapy is an evidence-based behavioral management intervention. Family treatment approaches include: The Beyond Consequences Model and Bruce Perry's Neuro-sequential Model (see resource list).

5. **Individual psychotherapy** for the child is considered adjunctive to working with the family. It can be helpful to work with children at their developmental level on skills such as: understanding emotions, social cues, understanding and responding effectively in interpersonal situations.

6. **Ongoing collaboration** with parents/caregivers, social services, teachers and medical providers is essential. The clinician needs to provide support and education about RAD to the primary caregivers and providers and help to create consistency between environments. Provide information about the persistent nature of

RAD and its effect on learning, behavior, social skills and family functioning. Educate caregivers about how children with RAD may respond and relate differently than other children in the home. There is often a need for ongoing intervention, focused either on RAD or secondary conditions.

7. **Support for parents/caregivers** is important to the success of treatment. This may include individual therapy and/or couples therapy to manage feelings of frustration, anxiety or anger. Support groups, such as parenting support groups, can be helpful to connect with other families, to mutually learn coping skills, and to help normalize their experiences. Recommend respite for parents to take breaks when needed.

8. **Adjunctive treatments** for families of children who also display aggressive and oppositional behavior may benefit from EBP's such as parent effectiveness training, multisystemic therapy and teaching caregivers about redirecting behaviors and utilizing natural consequences. Trauma focused therapies, such as Trauma Focused Cognitive Behavioral Therapy (TF-CBT), may also be helpful if indicated.

9. **Alternative treatments,** intended to provide "corrective attachment experiences" such as holding therapies, "rebirthing" techniques, or forced eye-contact have been denounced by research and there is no scientific evidence to support the effectiveness of such interventions. The use of such techniques has been associated with serious injury and even death, and at the very least can lead to humiliation and fear. Be wary of treatment approaches using the term "Attachment therapy" as this is a broad, vague term that sometimes includes non-evidence based approaches.

10. **Medication:** There is no medication to treat RAD itself. However, medications may be used to treat associated symptoms.

References and Resources for Clinicians

American Academy of Child & Adolescent Psychiatry (2005). *Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood*. 44 (24), NGC:004221. http://www.aacap.org/galleries/PracticeParameters/rad.pdf

American Psychiatric Association (2010). *Reactive attachment disorder: A review for DSM-V*. http://www.dsm5.org/Proposed%20Revision%20Attachments/APA%20DSM-5%20Reactive%20Attachment%20Disorder%20Review.pdf

Parent Child Interactional Training: Online Manual for clinicians
http://pcit.phhp.ufl.edu/Presentations/PCIT%20Integrity%20Checklists%20and%20Materials%204-13-06.pdf

Beyond Consequences Institute (bci) "Parenting Beyond Consequences, Logic, and Control: Towards a New Alternative to Behavior Modification and Understanding why Consequences are Ineffective"
http://www.beyondconsequences.com/freearticle.pdf

Child Trauma Academy
http://www.childtrauma.org/index.php/articles/cta-neurosequential-model