Reactive Attachment Disorder:

Help and Hope for Ambiguous Psychological Dismay

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Subject: Letter of Transmittal

Dear Mr. Michael Cable:

I am pleased to present my analytical report, "Reactive Attachment Disorder: Help and Hope for Ambiguous Psychological Dismay." My study describes the devastating causes, symptoms and effects of psychological attachment disorders in children – namely Reactive Attachment Disorder (RAD).

RAD is especially unique as it is one of the few psychological disorders that can be diagnosed in infants. RAD is also one of the few psychological disorders that does not have medically established parameters for its causes, symptoms, diagnostic criteria, and treatment. I believe my report will raise awareness about attachment and its crucial importance for a child's healthy, stable and thriving development.

I believe that because of the lack of an established RAD précis that

specifically describes what it is and what it is not, people are more susceptible to discouragement, disheartenment and hopelessness about RAD treatment and prognoses. But despite the absence of an approved overview for the above disorder, I firmly believe that RAD children and their families can have help and have hope! My report discusses RAD's initial established layout, describing the definition, causes, symptoms, diagnostic criterion, treatment, parenting tips and techniques as well as prevention strategies. The presented material will expose the help that is available and the hope RAD children and their families can be sure to have!

Thank you, as well, Professor Cable, for your motivating feedback on my work. After reading your remarks, I am encouraged to continue to produce all the best writing that's within me.

I am especially familiar with the above topic, so if you have any questions and/or concerns regarding the presented material, I am happily willing to discuss them.I am available at (952) 300-7542 or Katie_pritchard@yahoo.com. Thank you for your valuable time!

Sincerely,
Katherine L. Pritchard
Enclosure

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Abstract

Reactive Attachment Disorder (RAD) is one of the few recognized mental health disorders that can be diagnosed in infants. It is a disorder that suggests children are prone to the inability of forming healthy, loving relationships with others due to the lack of attachment or bonding with a guardian at an early age. As a result, children will more than likely be deprived of enriched social development or any kind of wholesome relationships. The following information gives readers a chance to explore RAD history, statistics, causes, symptoms, treatments, parenting techniques and prognoses. RAD is a difficult mental health disorder to be faced with; but as causes and symptoms are identified and as a diagnosis and treatment plan are established, beams of light can finally shine at the end of a dark and lonely tunnel. Though many families have dependents suffering from RAD, there is help and there is hope!
Keywords: Reactive Attachment Disorder (RAD); attachment; pathogenic; parenting; prevention; treatment; hope.

"Strangers were a fairytale full of possibilities not yet corrupted by reality while caregivers were the reality – and everything that couldn't be counted upon…"

-Donna Lynn Hope

Introduction

Overview

Example. A woman is approved to adopt a child - a two-year-old boy. As the little lad begins to grow, the mother notices something amiss in the youngster's behavior. He does not behave like other toddlers. He has emotional and unruly outbursts of a curious peculiarity. He is unusually fearful and uncommunicative and his mother is confused and worried. The poor woman grows exhausted as she strives to bond with the child she so desperately wanted. Nothing she says or does works. She knows that something made her son's outlook of the world become negatively and drastically warped. Does her child even realize how much his mother

loves him? Why does he feel so fearful and unsafe? Perhaps he doesn't know how to love? Or how to connect and bond? But why?

Help and hope. These are normal questions for families who have children suffering from what is described above: Reactive Attachment Disorder (RAD).

RAD children and their families have an additional hurdle to overcome, as well: Trying to find help and hope for the ambiguous psychological dismay that is Reactive Attachment Disorder. But while families who have children with attachment difficulties and/or disorders – (namely RAD) wait, they live with fear, hopelessness and/or chaos. But, have no doubt, this paper will prove that there is help and there is hope!

The diagnosis of Reactive Attachment Disorder first appeared in 1980 and modifications were made in 1987 and then again in1994. Criteria for Reactive Attachment Disorder was criticized as having no published studies using or evaluating its summation. The criteria itself was insufficient in describing children who have seriously disturbed attachment relationships. Research of both the criteria and the constructs of RAD began in 1994 and consistently show unreliable measures in diagnosing Reactive Attachment Disorder (Cross, 2003).

As of 2015, Reactive Attachment Disorder is still a relatively new condition; however, despite being new, RAD is a condition that has growing awareness about the negative effects of institutionalization and maltreatment of children and their psychological development. Although some improvements have been made to describe and identify RAD, making reliable diagnoses is still a major problem due to etiology disagreements among professionals (Wood, 2005).

According to the authors of "Disturbances/Disorders of Attachment in Children and Adolescents," "the systematic study of attachment disorder is relatively new, and is plagued by the problem that, even when studied, strict criteria for attachment disorder have not been used. Studies have instead used a variety of observational interview measures to index a behavioral pattern based on early clinical description" (Ashford et al., 2008). The authors list the necessary, yet absent, strict criteria tools:

a. State-of-the-art, goal-directed, evidence-based approaches that fit the main presenting problem should be considered when selecting a first-line treatment. Where no evidence-based option exists or where evidence-based options have been exhausted, alternative treatments with sound theory foundations and broad clinical acceptance are appropriate. Before attempting novel or highly unconventional treatments with untested benefits, the potential for psychological or physical harm should be carefully weighed.
b. First-line services for children described as having attachment problems should be founded on the core principles suggested by attachment theory, including caregiver and environmental stability, child safety, patience, sensitivity, consistency, and nurturance. Shorter term, goal-directed, focused, behavioral interventions targeted at increasing parent sensitivity should be considered as a first-line treatment.
c. Treatment should involve parents and caregivers, including biological parents if reunification is an option. Fathers, and mothers, should be included if possible.

Much research still needs to be done in order to improve the assessment and diagnostic process of RAD as well as to gain greater understanding of the overall disorder.(Wood, 2005).

The ultimate benefit of children will be best served by increased dialogue and information sharing between child abuse professionals, scientific researchers, and the attachment therapy (Barnett et al., 2006) Ultimately, continued separation between the worlds of attachment therapy and mainstream clinical science is not conducive to resolving these disagreements or promoting safe and effective clinical practices.

Definition

Child Development

Theory conceptualization. The difficulties in the conceptualization of RAD are because its causes are uncertain; it may not be feasible to diagnose RAD at all. It may be false to classify a disorder with little understanding

of the concept and evidence that is inconclusive. Certain sources may be presumptuous of its definition of RAD (Wood, 2005).

The quality of attachment in a child/caregiver relationship has a crucial effect on a child's future relationships and social success that it is considered of key importance in childhood development (Canter, 2008).

When a child fails to bond with a caring adult, attachment becomes disordered and may impede appropriate bonding in future relationships (Saisan, 2015). A history of neglect and/or abuse compromises the ability to form stable attachment with a primary caregiver, and will thus, (more often then not) result in Reactive Attachment Disorder (RAD) (Canter, 2008).

RAD is conceptualized as a condition resulting from pathogenic care and characterized by an inability to engage in social relationships or form emotional attachment to others (Glenn, 2015). Children with this condition may exhibit problematic behaviors due to deficits in social and emotional development as well as in other developmental areas (i.e., language, behavior, and communication) (Canter, 2008).

Beyond the age of three, children's attachment to others is based largely on language and communication, becoming increasingly entangled with cooperative activities, separation, and proximally based security (Canter, 2008).Children who experience maltreatment or removal of a significant caregiver during the early formative years are at risk for developing significant deficiencies in social relatedness, competence, and development. There is a greater likelihood of negative and incomplete social and cognitive development outcomes in maltreated children. The maladaptive behaviors extend to dysregulation, poor social skills development, and ultimately poor adaptation to the school environment (Canter, 2008).

Clearly, the conceptualization of RAD is still in its construction phase. Lack of adequate research on reactive attachment disorder is a hindrance to forming the well-defined definition of the disorder that is necessary for reliability and validity in its diagnosis (Wood, 2005).

Attachment theory. The idea of attachment (and, consequently,

attachment therapy) was sanctioned by British psychologist, John Bowlby. As he made his discoveries and developed his theories, scientists, researchers and other medical professionals began to take note of his medical and scientific research. Bowlby theorized, as was mentioned earlier, that attachment is crucial during a child's early developmental stages because that is when children recognize their entitlement to attention, praise, love (Davidson, 2013); a child's recognition to those rights provide a substantial foundation for future, positive relationships.(Davidson, 2013).

The construct of maternal sensitivity (i.e. appropriate, timely, and consistent responses to children's signals and needs) is central to attachment theory. It is also central to gaining understanding and working with parents through intervention methods (Ashford et al., 2008).

Traditional attachment theory holds that caregiver qualities such as environmental stability, parental sensitivity, and responsiveness to children's physical and emotional needs, consistency, and a safe and predictable environment support the development of healthy attachment. From this perspective, improving these positive caretaker and environmental qualities is the key to improving attachment. From the traditional attachment theory viewpoint, therapy for children who are maltreated and described as having attachment problems emphasizes providing a stable environment and taking a calm, sensitive, non-intrusive, nonthreatening, patient, predictable, and nurturing approach toward children (Barnett et al., 2006).

An attachment disorder is warranted when a child who is developmentally capable of forming attachments, with a minimum cognitive age of 9 months, does not because of an aberrant caregiving environment (Ashford et al., 2013).

M. Wood (2005), author of "Reactive Attachment Disorder: A Disorder of Attachment or of Temperament?" believed evolutionary thinking was the core of Bowlby's attachment theory. She writes:

Infants are vulnerable and unable to fend for themselves. Thus, the

attachment
process is designed to insure the survival of the infant and, in turn, the species. As
long as an infant is well loved and its biological needs are consistently met, he will learn to trust and feel secure with his caregiver, and a healthy attachment will be made. This attachment will continue to influence one's interpersonal relationships throughout life (pp. 2-3).
Attachment Caregiver(s). L. Ashford, D. Casey, J. Davidson, K. Dean & P. van Eys (2013) conclude that "psychological trauma in infancy/early childhood in which there is gross impairment in the caregiving system appears to cause adverse developmental effects" (p. 171).

It is clear that attachment disturbances and disorders occur in the context of psychological traumas so developmentally adverse that they block or interrupt the normal progression of development in periods when a child (usually in infancy and early childhood) is acquiring the fundamental psychological and biological foundations necessary for all subsequent development, including:(1) attention and learning; (2) memory; (3) emotion regulation; (4) personality formation and integration; and (5) relationships ...A positive view to take is that there are individual differences in the extent of impairment (Ashford et al., 2008).

Extremely pathological caregiving impacts the foundational architecture of the brain (e.g., neural circuitry structures). Psychological trauma and pathological attachment in the early developmental periods is likely to be complex in its effects, because it occurs in a one-time-only period of developmental growth (e.g., infancy/childhood) and/or developmental consolidation (adolescence). Learning across all domains (e.g., cognitive, emotional, social, physical) is predictably negatively affected (Ashford et al., 2008).

In the last few decades, significant discoveries have confirmed the importance of the parent/child relationship in the early years of a child's life. Research has verified the need for immediate and continuous stable attachment due to the long lasting impact on the child's future behaviors

and relationships.(Ashford et al., 2013).

K. Cross (2003), a Licensed Clinical Social Worker Specialist at the Attachment Center of Kansas, reiterated the need for stability (a need that was substantiated by previous research), and stated that "the early relationship between the primary caretaker and the infant influences the child's developing cognitive processes, ability to recognize and manage emotions and empathize with the feelings of others and even determines the shape and functioning of the brain." (p. 1)

Research still needs to be done in order to improve the assessment and diagnostic process of RAD as well as to gain greater understanding of the disorder. Because of the significance of attachment formation, it is expected that disruption of the attachment process be associated with a variety of mental disorders. The question should be asked of whether attachment should merely be described as an issue associated with certain mental disorders or whether disorders, such as RAD, truly exist, stemming directly from the disruption of attachment early in life. Additional confusion is created by emphasizing socially aberrant behavior across a wide variety of contexts rather than focusing on behaviors more directly associated with disturbed attachments (Wood, 2005).

Generally speaking, secure attachment is seen as a protective factor for a child's healthy development. A caregiver's presence – whether physical, mental or emotional– plays one of the most significant roles in a child's initial growing stages. (Cross, 2003).

L. Ashford from the Tennessee Department of Mental Health and Substance Abuse Services (2013) states:

From the end of the first year until approximately three years of age, children insist on maintaining close proximity with their caregivers. They use their important attachment figures as a secure base from which they can explore the world and a safe haven to which they can return when distressed, fearful, hungry, or tired…This allows children to become confident that they are worthy of attention and affection, laying the groundwork for positive future relationships (p. 16).

Attachment problems result in distrust and a lack of self-regard, a fear of connecting with anyone, inability to control emotions, and a need to be in control themselves. A child with an attachment disorder feels unsafe and alone (Cross, 2003).

As shown in Figure 1.,M. Wood(2005) summarizes the definition of RAD in a simple yet profound way by saying, "Reactive attachment disorder is a severe disorder of social functioning. It has two subtypes: inhibited type, where the child will display wary and watchful behaviors and the disinhibited type, where the child displays indiscriminately friendly behaviors, engages socially with strangers, and shows no need to remain near the safety of their primary caregiver." (p.1)

Causes

Maltreatment

Unmet needs. C. Davidson (2013), one of the four contributing authors of an article in The Scientific World Journal entitled "Reactive Attachment Disorder in the General Population: A Hidden Essence Disorder" believes that RAD is a result of severe maltreatment in early childhood (p.1).

Reactive Attachment Disorder is a rare but serious condition in which an infant or young child's basic needs for comfort, affection and nurturing aren't met and loving, caring, stable attachments with others are not established (Saisan, 2015). This makes RAD one of the very few mental illnesses that can start in infancy ("Reactive attachment disorder", para. 1). A child whose needs are disregarded or met with a lack of heartfelt concern from a caregiver does not grow up to anticipate care, expect nurture, or even form a secure connection to caregivers. RAD can affect every aspect of a child's life and development (Buckner, n.d.).

When a child fails to bond with a caring adult, attachment becomes disordered and children may not be able to bond appropriately or at all with other people. This inability to relate and connect with others may disrupt or arrest not only children's social development, but also their overall development. A failure to bond may be generated by a variety of

early experiences (e.g., abandonment, neglect, abuse) characterized by pathogenic care.(Canter, 2008).

Abuse and neglect. Attachment disorders – including the extreme example of RAD – are the result of harmful and destructive experiences in a relationship between a child and a caregiver/guardian early in a child's life. RAD is a condition found in children who have received grossly negligent care and did not form a healthy emotional attachment with their primary caregivers before the age five (Davidson, 2013).

The attachment process. So why do some children develop attachment disorders while others do not? The answer is in the attachment process, which relies on the interaction of both parent and child (Saisan, 2015). As previously mentioned, attachment disorders are the result of negative experiences in this early relationship. If young children feel repeatedly abandoned, isolated, powerless, or uncared for—for whatever reason—they will learn that they can't depend on others and the world is a dangerous and frightening place (Saisan, 2015).

Children with secure attachment are more likely to have close friends, be more socially competent, more accepted by their peer group, have more empathy for others, more self-reliant, better problem solvers and be able to read emotional cues. Secure attachment is thought to be one of the protective factors involved in resiliency development. Children with (anxious) insecure attachment histories are found to be less confident and more reliant on others to have their needs met, and more at risk for psychosocial malfunctioning, such as somatic complaints, social withdrawal, depression and anxiety disorders. Avoidant children exhibit different forms of social incompetence - they are often identified as bullies by their peers and are hostile and aggressive (Cross, 2003).

Circumstances in Unhealthy Environments

Primary RAD causes. What causes a child to fail to connect with their caregiver? The authors of the HelpGuide.org article, "Attachment Issues and Reactive Attachment Disorder: Symptoms, Treatment, and Hope for Children with Insecure Attachment", J. Saisan, J. Segal, and M. Smith

(2015), provide a very important list by proclaiming that:

Reactive Attachment Disorder and other attachment problems occur when children have been unable to consistently connect with a parent or primary caregiver. This can happen for many reasons:
-A baby cries and no one responds or offers comfort.
-A baby is hungry or wet, and they aren't attended to for hours.
-No one looks at, talks to, or smiles at the baby, so the baby feels alone.
-A young child gets attention only by acting out or displaying other extreme behaviors.
-A young child or baby is mistreated or abused.
-Sometimes the child's needs are met and sometimes they aren't. The child never knows what to expect.
-The infant or young child is hospitalized or separated from his or her parents.
-A baby or young child is moved from one caregiver to another (can be the result of adoption, foster care, or the loss of a parent).
-The parent is emotionally unavailable because of depression, an illness, or a substance abuse problem.(pp. 1-2)

Situations in which children have been abused, bounced around in foster care, lived in orphanages, or taken away from their primary caregiver after establishing a bond are the primary causes of RAD (Saisan,2015).As the examples show, sometimes the circumstances that cause the attachment problems are unavoidable. To a young child, the situation must make them feel like no one cares; they unsurprisingly lose trust in others. They see the world as an unsafe place and behave in such a way that proves and demonstrates just that.

Signs and Symptoms

Societal Components

Relationships and symptoms. The causes have been identified. But what do the symptoms look like?

Many people conclude that "children with attachment disorders

crave power, control, and authority; are dishonest; have ulterior motives for ostensibly normal social behaviors and described by these proponents as being completely self-centered, often exhibiting a sense of grandiosity, lacking conscience" (Barnett et al., 2006, p. 79).

Common R.A.D. symptoms include problems across multiple domains (social, emotional, behavioral, relational and developmental). Examples of some common symptoms include the following: "Destructive behaviors; developmental lags; no eye contact; cruelty to animals and siblings; preoccupation with fire and blood; poor relationships; stealing; lying; no conscience; persistent nonsense questions or chatter; impulsivity; abnormal speech patterns; fighting for total control; and hoarding/gorging on food" (Barnett et al., 2006, pp. 82-83).

RAD symptoms are monumental burdens for a child to carry while they try to build and maintain positive, healthy relationships. The most experienced researchers established a thought provoking and profound conclusion when they identified the two possibilities for the types of societal relationships R.A.D. children have.

R.A.D. children's style of social relating occurs in one to two extremes: (a) indiscriminate/excessive attempts to receive comfort/affection from any available adult, (adolescents may aim attempts at peers) or (b) extreme reluctance to initiate/accept any comfort/affection, even from familiar adults, especially when distressed (Barnett et al., 2006, p. 80).

Survival mode is usually instigated in a baby once they are separated from their mother. The baby's breathing increases; they clench their fists; they arch their backs, and, tense their muscles. The longer caregivers fail to acknowledge these cues, the longer it will take for the baby to thrive. Growing infants grow and develop exceptionally well the more time they spend in touch and have interaction with their parent(s)/caregiver(s)(Sears, 2001).

Safety is the core issue for children with reactive attachment disorder and other attachment problems. They are distant and distrustful because

they feel unsafe in the world. They keep their guard up to protect themselves, but it also prevents them from accepting love and support. Trust and security come from seeing loving actions, hearing reassuring words, and feeling comforted over and over again (Saisan, 2015).

RAD Symptoms

Common examples. Barnett et al.,(2006) (and Figure 2)share "examples of some common symptoms" which include: "...superficial interactions with others, indiscriminate affection toward strangers, and lack of affection toward parents. Symptoms range from those under the RAD criteria listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (published by the American Psychiatric Association) to nonspecific behavior problems including destructive behaviors; developmental lags; refusal to make eye contact; cruelty to animals and siblings; lack of cause and effect thinking; preoccupation with fire, blood, and gore; poor peer relationships; stealing; lying; lack of a conscience; persistent nonsense questions or incessant chatter; poor impulse control; abnormal speech patterns; fighting for control over everything; and hoarding or gorging on food." Others have promulgated checklists that suggest that among infants, "prefers dad to mom" or "wants to hold the bottle as soon as possible" are indicative of attachment problems. Clearly, these lists of nonspecific problems extend far beyond the diagnostic criteria for RAD and beyond attachment relationship problems in general. These types of lists are so nonspecific that high rates of false-positive diagnoses are virtually certain" (pp. 82-83).

Medically proven RAD signs. Even though many of these accounting sexist, the following is a collection of medically proven, common RAD symptoms from the work "Disturbances/Disorders of Attachment in Children and Adolescents" by L. Ashford, D. Casey, J. Davidson, K. Dean and P. van Eys (2013):
-Doesn't smile
-Avoids eye contact
-Doesn't reach out to be picked up

-Rejects your efforts to calm, soothe, and connect
-Doesn't seem to notice or care when you leave them alone
-Cries inconsolably
-Doesn't coo or make sounds
-Doesn't follow you with his or her eyes
-Isn't interested in playing interactive games or playing with toys
-Spend a lot of time rocking or comforting themselves (pp. 169-170).

Milestones

Relationship to attachment. Various theories about RAD exist, and more research is needed to develop a better understanding. The article "What is Secure Attachment and Bonding? Understanding the Different Ways of Bonding and Communicating With Your Child" written by M. Glenn, L. Robinson and J. Segal (2015) and published on HelpGuide.org provides reassurance and recommendations. The authors state that "by understanding the developmental milestones related to secure attachment, someone can spot symptoms of insecure attachment and take steps to immediately repair them. If a child misses repeated milestones, it's crucial to consult with a professional" (p. 4).

Diagnosis

Diagnostic Criteria

Diagnosing tools. As in adults, mental health professionals diagnose psychological disorders in children based on interviews, behavioral observations, and assessment tools that suggest a specific problem.

The DSM-IV requires that children diagnosed with RAD have histories of pathogenic care, meaning experiences of parental abuse and neglect or lack of a consistent caregiver. Professionals do warn clinicians against diagnosing a child with RAD unless there is some evidence of pathogenic care. Given such implications, it stands to reason that children most likely to have RAD are those that come from abusive families or were raised in foster care or orphanages (Barnett et al., 2006).

RAD assessments are based on diagnostic criteria listed in the DSM-IV. Ratings on the two subtypes of RAD in maltreated toddlers were made based on several criteria (Wood, 2005).

Inhibited and Disinhibited. M. Wood (2005) with Rochester Institute of Technology explains:

The criteria for inhibited RAD is: (a) absence of a discriminated, preferred adult, (b) lack of comfort seeking for distress, (c) failure to respond to comfort when offered, (d) lack of social and emotional reciprocity, and (f) emotion regulation difficulties. The criteria for disinhibited RAD were: (a) not having a discriminated, preferred attachment figure, (b) not checking back after venturing away from the caregiver, (c) lack of reticence with unfamiliar adults, (d) a willingness to go off with relative strangers. Upon rating the children in this study, researchers found that the two subtypes of RAD as described by the DSM-IV are not completely independent. Rather, children with RAD may exhibit symptoms of both types of the disorder. (p. 3)

DSM-IV. The current definitions of RAD published in the DSM-IV are somewhat vague, and consequently, do not provide professionals with the best means in which to diagnose it as a disorder (Ashford et al., 2013).

Further complicating the challenges comorbidity and differential diagnosis create when identifying RAD, there is currently no universally accepted assessment tool for identifying children with RAD (Wood, 2005). The lack of such a tool creates a situation where many children may be misdiagnosed. In addition, not having a well-developed assessment protocol may potentially limit the possibility of generating and researching effective intervention strategies used in clinical and school settings…(Wood, 2005). Additionally, data from divergent sources support the notion that a history of neglect and/or abuse compromises the ability to form stable attachments with a primary caregiver, and thus might result in Reactive Attachment Disorder (RAD) (Barnett, 2006). The DSM-IV conceptualizes RAD as a condition resulting from pathogenic care and characterized by an inability to engage in social relationships or

form emotional attachment to others. (Canter, 2008, pp. 48, 51).

Adolescents are unable to convey their struggles with managing emotions or managing other symptoms associated with the disorder; diagnoses are primarily based on reports from caregivers and clinical observations made by professionals (Saisan, 2015).

Attachment-related problems may be under diagnosed, over-diagnosed, or both simultaneously. In general, rare conditions may be missed by some clinicians simply because of unfamiliarity. They also may be over-diagnosed by proponents. There are no studies examining diagnostic accuracy among the increasing numbers of children who are maltreated being described by clinicians as having an attachment disorder (Barnett et al., 2006).

Diagnosing Difficulties

False diagnoses. Like with any other kind of mental illness, false diagnoses are always
an unfortunate possibility; to reduce the risk of diagnosing an inaccurate disorder, it is essential
that thorough medical investigations are executed and completed on a case by case basis (Wood,
2005).

Further complicating the challenges of identifying RAD, there is currently no universally
accepted assessment tool for identifying children with the aforementioned disorder. The lack of such a tool creates a situation where many children may be misdiagnosed. In addition, not having a well-developed assessment protocol may potentially limit the possibility of generating and researching effective intervention strategies used in clinical and school settings (Canter, 2008).

In addition, several other disorders share substantial symptom overlap with RAD and,
consequently, are often comorbid with or confused with RAD. Just as it is important not to miss the presence of an uncommon condition in a child,

it also is important not to diagnose an uncommon and dramatic disorder when the diagnosis of a common but less exciting disorder is more appropriate. Although more common diagnoses may be less exciting, they should be considered as first-line diagnoses before contemplating any rare condition, such as RAD or an unspecified attachment disorder (Barnett et al., 2006).

Continuing to make inquiries is important, as well. Inquiries such as: Is the caregiver providing unbiased reports of their child or are their assessments a reflection of their own hypersensitivity? Are the doctor's observations based on the child's natural temperament or are they the result of possible abuse? Children who naturally have difficult temperaments may certainly display symptoms of RAD. In addition, due to the vague diagnostic criteria of RAD, a Mental Health professional's inaccurate conclusions are more possible (Wood, 2005).

M. Wood(2005) asks a profound question when she states, "Moreover, given that the diagnosis for RAD includes the presence of a maladaptive caregiver, if a child develops symptoms that are characteristic of RAD but has not suffered any form of abuse, what diagnosis would the child receive?" (p. 9)

Treatment

Attachment Based Therapies

Children with and without RAD. Treatment for reactive attachment disorder usually involves a combination of therapy, counseling, and parenting education, designed to ensure the child has a safe living environment, develops positive interactions with caregivers, and improves peer relationships. While medication may be used to treat associated conditions, such as depression, anxiety, or hyperactivity, there is no quick fix for treating reactive attachment disorder. (Saisan, 2015).

Children diagnosed with RAD appear to demonstrate significantly more behavioral problems and psychosocial difficulties than children without RAD (Buckner, n.d.).

Buckner Dunkel, Joiner, and Lopez claim in their article “Behavior Management Training for the Treatment of Reactive Attachment Disorder” (n.d.) that “there have been few examinations of empirically informed treatments for this disorder. One avenue that may be particularly promising is the use of treatments that have been successfully used to decrease similar problematic behaviors in children.” (p. 1).

Holding therapy. Most existing treatments for RAD are attachment-based therapies. Perhaps the most publicized of these treatments is holding therapy, also known as rebirthing or rage reduction therapy. These therapies are based on the premise that the behavioral features of RAD are the consequence of suppressed rage occurring in children who experienced pathogenic care (Cross, 2003). Healthy attachment is thought to be able to occur at the point the child's rage is released through the restraining and noxious stimuli portion of treatment. (Buckner et al., 2008) Holding therapies however, are at certain times criticized because, as a result of being geared towards children who have experienced severe abuse or neglect, they can perpetuate further trauma for a child with a similar history. (Buckner et al., 2008)Those kinds of criticisms in addition to a lack of supportive data and/or other empirical evidence necessitate the need for alternative RAD treatments (Cross, 2003).

Alternative Treatments

Therapeutic techniques. Even though holding therapies are the most well-known of attachment therapies, they are also the most controversial. In addition to holding therapies, there are other therapeutic techniques that are used for RAD children such as art therapy, play therapy, music therapy, etc. (Buckner et al., 2008) Many treatments have been considered successful in the decline of numerous behavioral difficulties. But in the absence of empirically maintained RAD treatments, it is reasonable and important to address symptoms by exploring the use of other medically documented therapies and effective,

alternative treatments. (Buckner et al., 2008).

There is importance placed on building parents' strengths and promoting parental competence and control over life. Derived from attachment theory, the "Circle of Security" is a relationship-based intervention designed to change child behavior through changes in the parental behavior. The underlying premise is that the parent is a secure base from which young children can leave and explore their surroundings. Caregivers read and attend to child cues during exploration. Children then return to the safety and security of the caregiver base. The treatment plan is tailored to address the parent child dyad and to address the challenges that occur within that circle of exploration and safe return. The "Circle of Security" protocol consists of pre-intervention videotaped structured assessment. This is followed up by group based parent education and psychotherapy lasting about 20 weeks using videotaped intervention. The goals of this video review are to increase the sensitivity to the child's cues, increase self-other reflective capacity, and explore new representations and interaction patterns. Parents of children described as having attachment problems may benefit from ongoing support and education. Parents should not be instructed to engage in psychologically or physically coercive techniques for therapeutic purposes, including those associated with any of the known child deaths. It is worth highlighting that one consistent component across models is parenting practices and that caregiver participation is an essential component of treatment. Most emphasize parental attunement or sensitivity to the child's needs, and the treatment focuses on building that relationship through consistency, responsiveness, and predictability (Ashford et al., 2008).

There is an important point to make about the current state of RAD and its status in the field of psychology. Buckner et al. declares the following:

As no empirically supported interventions currently exist to treat children with RAD, it seems appropriate to examine the utility of treatments…for disorders that exhibit considerable symptom overlap

with RAD... Treatments aimed at managing behavior problems are indicated as RAD is associated with problems concerning attention as well as aggressive and defiant conduct. (Buckner et al., 2008)

Treatment Summary

Treatment verses no treatment. Treatment has two parts. The first goal is to make sure the child is in a safe environment where emotional and physical needs are met. Once that has been established, the next step is to change the relationship between the caregiver and the child, if the caregiver has caused the problem. Classes on parenting skills can help. These skills give the caregiver the ability to meet the child's needs and bond with the child. The caregiver should also have counseling to work on any current problems, such as drug abuse or family violence. Social Services should follow the family to make sure the child remains in a safe, stable environment.

Parents who adopt babies or young children from foreign orphanages should be aware that this condition may occur and be sensitive to the child's need for consistency, physical affection, and love.

These children may be frightened of people and find physical affection overwhelming at first, and parents should not view this as rejection. It is a normal response in someone who has been abused to avoid contact. Hugs should be offered frequently, but not forced.

A mental health evaluation should be completed. This evaluation will be helpful in developing a treatment plan (“Reactive attachment disorder,” n.d.)

Learning about what treatments have been effective can aid in developing proper theories for the disorder. If no treatments have been effective in treating the disorder, then maybe Reactive Attachment Disorder is more like a personality disorder in children. If no treatments are shown to be effective for treating RAD, then maybe RAD could better be characterized as a personality disorder of children rather than an Axis I DSM disorder. Although determining causal factors may provide enlightenment into the development of the disorder and possible

treatments, for purposes of reliable diagnosis the disorder must first be operationally defined. One can only hope that subsequent editions of the DSM will provide improved definitions of the disorder and what it entails (Wood, 2005).

Without treatment, RAD can continue for several years and may have long-lasting implications (Wood, 2003). Children with RAD are believed to have the capacity to form attachments, but this ability has been compromised by their experiences (Canter, 2008). There is no medication to treat RAD itself but the doctor may sometimes use a medication as an adjunct to treatment to help manage severe behavioral symptoms (Saisan, 2015).

The best treatment for a child with RAD is a positive, loving, stable, caring environment and caregiver. It is insufficient to treat the child's clinical issues as the mechanism for forming an attachment with the primary caregiver. These issues did not cause the attachment disorder, and therefore correcting them is not sufficient to correct the disorder (Cross, 2003). Treatments for RAD include positive child and caregiver interactions, a stable, nurturing environment, psychological counseling, and parent/caregiver education. (Buckner et al., 2008)

Parenting

Methods and Tips

Self-care. It is to be expected that parents and caregivers of RAD children will at times become angry, frustrated and distressed. Finding someone to step in and give the caregiver a break is a wise way in which RAD parents can rejuvenate and rest. Practicing stress management skills, making time for solitude, and acknowledging that it is alright to feel frustrated or angry are other methods in which parents can successfully meet the demands of raising a child with RAD (Saisan, 2015).

Importance of the Parent/Caregiver Role

The "attachment bond". The main predictor of how well a child will do

in school and later in life is the strength of the relationship they have with their primary caretaker. This relationship impacts a child's future mental, physical, social, and emotional health. It is not founded on quality of care or parental love, but on the nonverbal emotional communication between child and parent. This is known as the "attachment bond". This form of communication affects the way a child develops mentally, physically, intellectually, emotionally, and socially (Glenn, 2015).

In their article, Glenn, Robinson and Segal (2015) state that "by understanding the developmental milestones related to secure attachment, someone can spot symptoms of insecure attachment and take steps to immediately repair them. If a child misses repeated milestones, it's crucial to consult with a professional" ("Developmental milestones related to," para. 1). A parent is able to check with their child's pediatrician or social service agency to obtain available community resources for help (Saisan, 2015).

Attachment Parenting

Children's needs. Since the concept of "attachment parenting" hit the field of psychology, views about caretakers and the roles they play in the lives of children, changed (Barnett, 2006). Research shows the following:

Children need something more than love and caregiving in order for their brains and nervous systems to develop in the best way possible. Children need to be able to engage in a nonverbal emotional exchange with their primary caretaker in a way that communicates their needs and makes them feel understood, secure, and balanced. Children who feel emotionally disconnected from their primary caregiver are likely to feel confused, misunderstood, and insecure.

While it's easiest to form a secure attachment bond when a child is still an infant—and reliant upon nonverbal means of communicating—a parent can begin to make their child feel understood and secure at any age. Children's brains continue maturing well into adulthood (until their mid- 20s). Moreover, because the brain continues to change throughout

life, it's never too late to start engaging in a nonverbal emotional exchange with a child. In fact, developing nonverbal communication skills can help improve and deepen a parent's relationships with other people of any age. (Glenn et al., 2015, "The bond of love", para. 1-3)

According to Dr. K. Huey (2012) of the CALO Attachment Disorder Residential Treatment Center, "If there is a relationship component to the emotional and behavioral disturbances then there ought to be a relationship focused paradigm that helps correct that." [Video file].

Children need something more than love and caregiving in order for their brains and nervous systems to develop in the best way possible. But a man or woman doesn't have to be a perfect parent to build a secure attachment bond with their infant—no one is able to be fully present and attentive to a child 24 hours a day. But because the brain is capable of changing, repair is always possible and may even strengthen the secure attachment bond (Glenn, 2015).

Experience shapes the brain which is especially true for newborns whose nervous systems are largely undeveloped. Fortunately, as the infant brain is so undeveloped and influenced by experience, a child can overcome any difficulties at birth. It may take a few months, but if the primary caretaker remains calm, focused, understanding, and persistent, a baby will eventually relax enough for the secure attachment process to occur (Glenn, 2015).

According to Glenn et al. (2015), authors of the article "What is Secure Attachment and Bonding? Understanding the Different Ways of Bonding and Communicating With Your Child," it's important for a parent to "notice a disconnect in the relationship or if they missed their child's cues, but still attempted to figure out their child's needs so the attachment process stays on track. The effort… can deepen trust, increase resiliency, and strengthen the relationship." ("Developmental milestones related to," para. 1-3).

Wordless Communication

Nonverbal cues. Nonverbal cues and how they can be used to create a

secure attachment bond include: eye contact, facial expression, tone of voice, touch, body language, pacing, timing and intensity. As there are many reasons why a loving, conscientious parent may not be successful at creating a secure attachment bond, there are three unique methods to help the process: first, understand what the attachment bond looks like; second, focus on one's own feelings to create a secure attachment bond; and finally, learn how to build a strong attachment relationship. (Glenn et al., 2015, "The bond of love", para. 1-3).

Prevention

RAD Risk Reduction

Reduction methods. While it's not known with certainty if RAD can be prevented, there are ways to reduce the risk of its development. Most parents want their children to grow up to be kind, affectionate, empathetic, well disciplined, and, of course, bright and successful. How a child is parented in the early years makes a monumental, life-changing difference when it comes to what kind of adults they will be (Glenn, 2015).

Preventing attachment disorders begins prior to the birth of the child and is mostly focused on holistic maternal health. Several preventive interventions in broad-based child development programs have shown promise for securing attachment in children and caregivers in high- risk population groups (Ashford et al., 2008).

Recent research suggests that early interventions that have targeted sensitivity have been found to be more effective in enhancing security than other interventions targeting other issues (such as parental state of mind). Furthermore, interventions that started after the child was at least six months old have been more effective than those starting earlier. This may be due in part to children beginning to show attachment to specific caregivers during this time period. A number of attachment based interventions can highlight mothers' strengths (i.e., appropriate response) and weaknesses (i.e., missed opportunities to respond) by

providing feedback. Successful interventions with infants should be started after age six months, be short term, focused, and goal-directed, with an emphasis on increasing sensitive caregiver behaviors, rather than focusing on child pathology. Finally, interventions implemented in families in which the infants are considered to be at risk (due to prematurely, irritability, or international adoption) are more effective than interventions with at-risk parents. It might be easier to prevent or change disorganized attachment when the parent is relatively well functioning and free of psychopathology (Ashford et al., 2008).

Popularly known as a "parenting expert", W. Sears (2001), encourages other parents when he states that, "Before a baby's birth, a parent imagines what the journey will be like. A parent's journey to become attached to their child will be different from other parents' journeys, because their child is an individual, and so is the parent" (p. 3).

The ABC's of Parenting

The ABC's of Attachment Parenting

A's	*B's*	*C's*
Accomplished	Birth bonding	Caring
Adaptable	Breastfeeding	Communicative
Adept	Babywearing	Compassionate
Admirable	Bedding close to baby	Confident
Affectionate	Belief in baby's cry	Connected
Anchored	Balance and boundaries	Considerate
Assured	Beware of baby trainers	Cuddly
—	—	Curious

Parental requirements. Professionals in the psychology field have determined that parents and caretakers need additional education to make Attachment Parenting a success; it is essential to their child's

welfare. A powerful starting off point for parents who are ready to implement Attachment Parenting in the relationship with their child is described in the following:

Attachment Parenting, like any job, requires a set of tools…A parent should think of Attachment Parenting as connecting tools, interactions with a parent's infant that help them and their child get more connected. Once they are connected, the whole parent-child relationship (disciplines, health care, and just plain day-to-day living with a child) becomes more natural and enjoyable… The tools of attachment are the Baby B's. The Baby B's help parents and baby get off to the right start. The attachment tools a parent uses with a new baby are based on biological attachment between mother and baby as well as on the behaviors that help babies to thrive and parents to feel rewarded for their efforts. When a parent practices the Baby B's of Attachment Parenting, their child has a greater chance of growing up with the qualities of the A's and C's. (Sears, 2001, p. 3-4).

In the article, "Reactive attachment disorder of infancy or early childhood," the author claims that, "…early recognition is very important for the child. Parents who are at high risk for neglect should be taught parenting skills. The family should be followed by either a social worker or doctor to make sure the child's needs are being met." ("Reactive Attachment Disorder", n.d.)

Needs of a Child

Intervention and children's needs. Ways in which to ensure the needs of a child are being met include but are not limited to the following:

-Educate yourself about attachment issues if your child has a background that includes institutions or foster care.

-Take classes or volunteer with children if you lack experience or skill with babies or children.

-Be actively engaged with your child by lots of playing, talking to him or her, making eye contact, and smiling.

-Learn to interpret your baby's cues, such as different types of cries, so

that you can meet his or her needs quickly and effectively.
-Provide warm, nurturing interaction with your child, such as during feeding, bathing or changing diapers.
-Offer both verbal and nonverbal responses to the child's feelings through touch, facial expressions and tone of voice.
-Recognizing a problem with attachment and providing interventions as soon as possible are essential to preventing RAD.

Recognizing a problem with attachment and providing interventions as soon as possible are essential to preventing R.A.D.

It is imperative that children with RAD learn to regulate their feelings and actions. This learning will only occur with deliberate and consistent instruction. Creating a reliable, predictable, and secure learning environment are essential considerations when developing interventions for children with RAD. Given the history of maltreatment and distrust children with RAD have with adults, it is imperative that those entrusted with developing the intervention plans are well versed in attachment theory and development in order to create a plan of benefit and not detriment to the child (Canter, 2008).

Conclusion

Persevering and hard-working parents who are raising an RAD child are not encouraged and commended for their effort and exertion enough. It is imperative that children with RAD learn to regulate their feelings and actions. This learning will only occur with deliberate and consistent instruction. Creating a reliable, predictable, and secure learning environment are essential considerations when developing interventions for children with RAD. Given the history of maltreatment and distrust children with RAD have with adults, it is imperative that those entrusted with developing the intervention plans are well versed in attachment theory and development in order to create a plan of benefit and not detriment to the child. (“Reactive Attachment Disorder,” n.d.)

If the mental health community cannot agree if Reactive

Attachment Disorder exists, criteria for symptoms, what assessments should assess and even if it should receive much attention due to being "rare" then it is no wonder that determining an "empirically supported" treatment for Reactive Attachment Disorder has received little attention since it was recognized over 20 years ago. Children with Reactive Attachment Disorder and their families cannot wait until these disputes and criticisms are resolved (Cross, 2003). RAD is a difficult mental health disorder to be faced with, but as causes and symptoms continue to be identified and as diagnostic criteria and treatment plans are established, light can finally shine at the end of a dark and lonely tunnel. Learning different parental techniques and accepting professional treatment for RAD will provide physical, emotional, and mental relief and give an optimistic, unbreakable hope; it is a hope that a parent and child can certainly be attached to while learning to bond with each other.

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