Informational Resources

This is an informational list only and is not intended as an endorsement of any specific organization, agency or individual.

Due to the uniqueness of the treatment required for this disorder, there are very few, or limited local resources. The following are starting points for further information regarding diagnosis, treatment, and support for caregivers.

The Adoption Exchange
3930 East Patrick Lane, Suite 120
Las Vegas, NV 89120

Evergreen Consultants in Human Behavior
28000 Meadow Drive, Suite 206
Evergreen, CO 80439

J. F. Alston, M.D.
30752 Southview Drive, Suite 100
Evergreen, CO 80439

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Hughes, D. (1997). Facilitating Development Attachment. Jason Aronson, Northvale, NJ

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R A D

REACTIVE ATTACHMENT DISORDER

Developing an Understanding Through Information

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It must be stressed that this document is intended to provide information only and should not be used to replace professional consultation, diagnosis, or treatment.

Reactive Attachment Disorder (RAD) is any disruption in the attachment process resulting in a child's failure to form a SECURE bond/attachment with a parental figure (Bowlby, 1988). Secure attachment forms when a child's physical and emotional needs are consistently met, especially during the first two years of life.

Because children trust that the parental figure will be there, they will internalize an image of their world as safe, stable, and dependable – in other words, SECURE. Children will develop independence while at the same time maintaining a connection with their parents or parental figures/care-givers. The child will learn to engage in mutually enjoyable interactions where the interaction itself is the end goal.

Secure Attachment and RAD are best understood as a continuum (Beck, 2000). The most securely attached people are confident, high functioning individuals with a strong sense of self-worth, highly developed empathy and the ability to engage in healthy, mutually enhancing relationships, both within and beyond their immediate families. The most unattached people are violent psychopaths, people without empathy or conscience, unable to relate to others except as objects to meet their needs.

Fortunately, most youth with this diagnosis fall are closer to the attached than the unattached end of this continuum. Only in very extreme cases do we see the severity of behavior typical of a true psychopath or conscienceless individual.

RAD generally develops in the period from birth to three years. Recent research indicates development of this disorder may begin in the womb (Beck, 2000). A child may experience birth trauma due to inadequate medical care. Certainly, Secure Attachment begins in the womb. As the mother goes about her daily routine, she begins the bonding process through the sound of her voice. The newborn child recognizes its mother's voice and smell and responds to her immediately. Such attachments also can begin during this period with the father or other adults closely involved in the mother's and infant's life.

There are many reasons why this attachment process is disrupted (Ward, 2001). A few of the contributing factors to impaired attachment are:

- Premature birth
- En utero trauma such as exposure to alcohol, drugs or other toxic substances
- Severe abuse or neglect in the first three years of life
- Postpartum depression in mother (making her emotionally absent)
- Insensitive parenting
    - ❖ A baby cries and no one comes
    - ❖ A wet or dirty diaper is left unchanged for extreme periods of time
    - ❖ No one smiles at the baby or interacts with him or her in a positive way
    - ❖ A baby is generally ignored and is only able to get attention through extreme misbehavior or by being overly cute
- Severe emotional or physical abuse
- Separation from birth mother or other nurturing adults
- Multiple caregivers without consistent and positive interaction and relationships
- Sexual abuse as an infant – especially by care-providers
- Frequent or multiple hospitalizations – with long periods of inattention
    - ❖ Unresolved pain
    - ❖ Painful or invasive medical procedures

These children have learned at a preverbal level that their world is a scary and distrustful place. This lesson has been imprinted at a biochemical level in the brain. This inhibits the positive response to traditional therapy or parenting since both rely on the child's ability to form relationships that require trust and respect.

Some typical tendencies and behaviors of those suffering from RAD include, but are not limited to:

- Superficially charming and engaging
- Indiscriminately affectionate with strangers or attempts to leave with strangers
- Lacks genuine affection with primary caregivers (especially mother)
- Refuses, resists, or is uncomfortable with affection on parental terms
- Hyperactive, overactive, or attention deficit
- Destructive to property, cruelty to pets, aggression towards self, or others
- Significant learning problems or lags
- Fire setting (revenge motivated, malicious), fire play, or fascination with fire
- Intense control battles
- Controlling, manipulative, defiant, argumentative, demanding, impulsive
- Poor, underdeveloped, or no conscience
- Preoccupation/fascination with fire, death, blood, or gore
- Daily lying, or lying in the face of the obvious (crazy lying)
- Rages or long temper tantrums, especially in response to adult authority
- Poor eye contact, except when lying
- Lack of self-control
- Lacks cause and effect thinking
- Blames others for their problems
- Hoards or sneaks food, strange eating habits

Some of these indicators may be present at any given time in any young person. For this reason, it is imperative to have an assessment for RAD performed by a professional who is well versed, or specializes in RAD diagnosis and treatment. Also keep in mind that it is multiple indicators rather than one or two behaviors that leads to the RAD diagnosis.

Due to the nature of this disorder, traditional therapeutic interventions are essentially ineffective. Treatment of this disorder is long-term, with a good chance of success – if diagnosis and treatment are early in the child's development- usually before age 12 (Ward, 2001; Cline, 1999). Pharmacological treatment may include Wellbutrin, Clonidine and Guanfacine as useful additive medications. According to Susan Summers, Project Coordinator for The Adoption Exchange, local treatment resources are extremely scarce in Southern Nevada. Please see resource list at the end of this Fact Sheet.

Long-term continuation of this disorder may lead to further deterioration of behavior, with increasing levels of manipulation and violence as the child moves into adolescence (Magid, 1988). Treatment at this point is extremely difficult with poor prognosis for success.

The primary goals of treatment and therapy are to resolve the fear of loving and being loved. In order for this to happen, the wounds of loss, abandonment, abuse and/or neglect must be healed. This is a specialized skill that involves the child as well as the primary caregivers.

Some treatment models used in RAD treatment include the following:

Inner Child Work	Re-Parenting
Cognitive Restructuring	Cognitive Behavioral Therapy
Insight Oriented Therapy	Supportive Psychotherapy
Holding Therapy - very controversial	Psychodrama
EMDR	Sensory Integration
Imagery	Social Skills Building
Body/Mind approaches	Theraplay

Parenting techniques with RAD children include a more structured approach that is balanced with nurturing. It is imperative for caregivers to understand the child's vulnerabilities, while maintaining control of the relationship so the child does not feel he/she has to in order to feel safe.