ACA-PBs
American Counseling Association Practice Briefs
The Center for Counseling Practice, Policy, and Research
counseling.org/practice_briefs | 703-823-9800 x324

July 2015

Reactive Attachment Disorder

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Description of Reactive Attachment Disorder

Definition

Reactive attachment disorder (RAD) is categorized as a Trauma- and Stressor-Related Disorder in the fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013). A RAD diagnosis may be assigned to children who have experienced gross neglect by caregivers and who subsequently have significant problems forming healthy, selective attachments to others. Children who exhibit RAD may demonstrate contradictory behaviors in social situations, including hypervigilance (intensely scrutinizing caregivers' responses), ambivalence (not responding to caregiving), and incongruence (initiating social connections with caregivers then rebuffing caregivers' responses). Although RAD symptoms may co-exist with other intellectual and developmental delays, RAD behaviors are not attributed to other mental health issues, medical disorders, or developmental delays. A RAD diagnosis may be considered for children older than 9 months of age who exhibit a range of unique and inappropriate social behaviors before age 5.

It is important to note that in the *DSM-IV-TR* (4th ed.; text rev.; APA, 2000), there were two types of RAD: the Inhibited Type, which constitutes what is characterized as RAD disorder in the *DSM-5*; and the Disinhibited Type, which is identified as disinhibited social engagement disorder (DSED) in the *DSM-5*.

Resources:

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Mayo Clinic. (2014, July 10). *Reactive attachment disorder*. Retrieved from http://www.mayoclinic.org/diseases-conditions/reactive-attachment-disorder/basics/definition/con-20032126

Prevalence

RAD is a relatively rare disorder that is challenging to diagnose within the general population. When observed, it most often occurs among very young children who have experienced severe neglect and abuse from early childhood. Although children who have been institutionalized or are in foster care represent many of those with RAD, RAD is present in only about 10% of this population. It is hard to determine the exact prevalence of RAD because of limited research and difficulty differentiating between behaviors indicative of RAD and those attributable to other developmental delays and disorders.

Resource:

American Academy of Child and Adolescent Psychiatry. (2011, March). *Reactive attachment disorder*. Retrieved from http://www.aacap.org/aacap/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Reactive_Attachment_Disorder_85.aspx

IDENTIFICATION/ASSESSMENT STRATEGIES

It is important for counselors to utilize a multidisciplinary and comprehensive diagnostic approach by collaborating with other professionals to gather observations and specialize treatment efforts (Sheperis et al., 2003; Sheperis, Renfro-Michel, & Doggett, 2003). Counselors should collect information directly from children and their caregivers, teachers, previous case workers, and medical practitioners regarding both historical and current attachments. As part of this information gathering process, counselors need to create opportunities to observe interactions between children and caregivers, especially noting dynamics that occur when children and caregivers separate and then reunite. These observations can yield important information regarding attachments between

children and their caregivers, a critical part of accurately diagnosing and treating RAD. Further, RAD assessment should include the observation and comparison of results of interactions between children and their caregivers versus children and unfamiliar adults. It is important that counselors carefully consider how their own and others' culture may impact observations of attachment to avoid misinterpreting, and potentially pathologizing, various attachment styles and presentations (APA, 2013).

Concomitantly, RAD assessment includes ruling out the presence of other developmental disorders and identifying co-occurring disorders, such as attention-deficit/hyperactivity disorder (often comorbid with DSED) and depressive disorders (often comorbid with RAD).

Although there are very few inventories designed to evaluate attachment disorders specifically, numerous screening tools may be utilized to more clearly determine the presence of RAD or other symptoms related to attachment disorders (Sheperis et al., 2003). An overview of these assessments is provided below.

Story Stem Assessment Profile (SSAP; Hodges & Steele, 2000; Hodges, Steele, Hillman, Henderson, & Kaniuk, 2005)

The Story Stem Assessment Profile (SSAP) is a battery composed of 13 story beginnings, designed to ascertain a child's expectations of parents or caregivers. The assessment is appropriate for children ages 8 and younger. A counselor reads each story stem aloud while acting out the story with dolls and animals, and then asks the child, "Show and tell me what happens next." The child narrates the rest of the story using the figurines. The stories contain 39 different themes, which are coded using a 3-point scale to form constructs such as security, disorganization, and/or positive or negative representation of adult and child (Hodges, Steele, Hillman, & Henderson, 2003). Training is required for use by counselors.

Relationship Problems Questionnaire (RPQ; Minnis, Rabe-Hesketh, & Wolkind, 2002)

The Relationship Problems Questionnaire (RPQ) is a 10-item inventory given to caregivers who respond to questions about their child's typical behavior. The questionnaire was designed to assess behaviors in children over the age of 5. The RPQ may also be administered to teachers in order to obtain multiple sources of information about a child's behavior (Vervoort, Schipper, Bosmans, & Verschueren, 2013). No additional training is required for use by licensed professional counselors.

Reactive Attachment Disorder – Checklist (RAD-C; Hall, 2007)

The Reactive Attachment Disorder Checklist (RAD-C) is a 17-item inventory based upon the *DSM-IV-TR* RAD criteria. To date, it has not been modified since the publication of the *DSM-5* (C. Hall, personal communication, June 15, 2015). The inventory may be given to parents who respond to items regarding typical behavior of their adolescent or child, specifically rating the frequency of certain behaviors using a scale from 1 to 5 (Thrall, Hall, Golden, & Scheaffer, 2009). No additional training is required for use by licensed professional counselors.

Child and Adolescent Psychiatric Assessment - Reactive Attachment Disorder Module (CAPA-RAD; Angold & Costello, 2000)

The Child and Adolescent Psychiatric Assessment - Reactive Attachment Disorder Module (CAPA-RAD) is a 28-item semi-structured interview that may be administered to parents and children. The module specifically assesses RAD symptoms as components of the overall CAPA. **Clinicians may use the CAPA-RAD as a diagnostic interview with parents of children and adolescents ranging from ages 9 to 17-years-old to assess their behaviors over the most recent three months** The main sections of the CAPA-RAD assessment examine psychiatric symptoms, functional impairment, demographics, family structure, and functioning. Training is required for use by counselors.

Disturbances of Attachment Interview (DAI; Smyke & Zeanah, 1999; Smyke, Dumitrescu, & Zeanah, 2002)

The Disturbances of Attachment Interview (DAI) is a 12-item semi-structured interview that trained clinicians may administer to caregivers to evaluate a child's inhibited and disinhibited behaviors. The first 5 items of the DAI are used to assess a child's inhibited behaviors; the last 7 items are used to assess disinhibited behaviors.

Reactive Attachment Disorder Scale (RADS; Hall & Geher, 2003)

The Reactive Attachment Disorder Scale (RADS) is an 85-item inventory, based upon *DSM-IV* RAD criteria. To date, there are not any available modifications for the *DSM-5*. Caregivers respond to questions within the RADS regarding observed behaviors of their child. No additional training is required for use by licensed professional counselors.

Manchester Child Attachment Story Task (MCAST; Green, Stanley, Smith, & Goldwyn, 2000)

The Manchester Child Attachment Story Task (MCAST) is a representational assessment used to identify attachment styles of school-aged children. The MCAST is composed of six test vignettes; five vignettes are "distress" situations, and one is an "achievement" scenario. To administer the MCAST, a clinician conducts a 20 to 30 minute interview with a child, during which the vignettes are presented, one at a time, to the child. The clinician observes how the child responds to the vignettes using doll-play and offers structured probes between each vignette. The play is videotaped. When clinicians review the recorded play, they code the child's behavior and discourse. The coding typically takes two to three hours to complete. Each vignette has 33 codings that are based upon a 9-point continuous scale; these codings relate to four broad categories that can be utilized to determine the attachment styles of the child. Training is required for use by counselors.

Other useful, more global assessments of RAD include the following (Gleason et al., 2011; Pritchett et al., 2013): Bear-Dragon (Kochanska et al., 1996); Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992); Child Behavior Checklist (CBCL; Achenbach, 1991); Development and Well-Being Assessment (DAWBA; Goodman et al., 2000); Eyberg Child Behavior Inventory (ECBI; Eyberg, 1999); Infant Toddler Social Emotional Assessment (ITSEA; Carter & Briggs-Gowan, 2002; Carter & Briggs Gowan, 2006); Preschool Age Psychiatric Assessment (PAPA; Egger & Angold, 2006; Egger et al., 2006); Social Skills Improvement System (SISS; Gresham et al., 2010); Strengths and Difficulties Questionnaire, (SDQ; Goodman, 1997; Goodman, 2001); Waiting Room Observation (WRO; McLaughlin, Espie, & Minnis, 2010); and the Wechsler Intelligence Scale for Children (WISC IV; Wechsler, 2003).

Resources:

The *RAD Infant Attachment Checklist* and the *RAD Child Attachment Checklist* are available for caregivers at: www.reactiveattachmentdisordertreatment.com/ssi/checklist.html

The *Disturbances Attachment Interview* is a supplement in the appendix of Gleason et al. (2011), and also is available online at: http://www.education.umd.edu/HDQM/labs/Fox/publications/124.pdf

INTERVENTION/TREATMENT STRATEGIES

Since a RAD diagnosis directly relates to severe maltreatment of a child, the first step of intervention or treatment involves assessing a child's safety. Once a secure environment for the child is established, the next treatment goal is to provide the child with a stable attachment figure (American Academy of Child and Adolescent Psychiatry, 2005). This may be accomplished by providing caregiver support and care, especially since many may struggle with guilt and insecurity associated with feeling unprepared to cope with the challenges inherent in raising children with RAD. Counselors may utilize a variety of strategies to help caregivers try to establish stable attachments with their children, including psychoeducation, dyadic developmental psychotherapy (DDP), and video interaction guidance (VIG).

Psychoeducation

Counselors initially may use psychoeducation as an evidence-based approach to help caregivers further develop their caregiving skills (Barkley, 1997; Barkley, 2013; Buckner, Lopez, Dunkel, & Joiner, 2008), especially to care for a child with RAD. For example, counselors may use psychoeducation to relay information to caregivers about attachment and RAD, such as what constitutes stable and unstable caregiver/child attachment, the etiology of RAD, symptomatic behaviors of RAD, and unique characteristics of RAD within a child. Psychoeducation then may be used to coach caregivers to look for cues from a child, identify and use various responses to best sooth a child or respond to attention seeking behaviors, and attend to a child's problematic behaviors while building a strong caregiver/child relationship (Cornell & Hamrin, 2008).

Dyadic Developmental Psychotherapy (DDP; Becker-Weidman & Hughes, 2008)

Dyadic developmental psychotherapy (DDP) is an evidence-based family therapy treatment for RAD, which focuses on the relationships between counselor and child, caregiver and child, and counselor and caregiver. The goals of DDP are to heal impairment resulting from past trauma and to build healthy attachments. As part of DDP, a child is ultimately helped to safely explore and develop healthy expressions, emotional regulation, coping strategies, and interactions. As each party – both caregivers and children – gain insight into individual and interpersonal functioning, the counselor models and directs caregivers in how to attend to their child, express empathy, and facilitate a secure attachment.

Video Interaction Guidance (VIG; Kennedy, Landor, & Todd, 2010)

Counselors may use video interaction guidance (VIG), an approach first developed and researched primarily in Europe, to help a caregiver recognize a child's communication style and respond to the child's desire for connection (Kennedy, Landor, & Todd, 2010). To do this, counselors videotape caregiver-child interactions and select positive examples of communication between the caregivers and children. Working with the caregiver, the counselor helps identify specific behaviors in the videotape to increase the caregiver's awareness of the child's initiation of communication and desire for connection. By analyzing these "moments of contact," (Gorski & Minnis, 2014, p. 386) the caregiver and child both have the opportunity to evaluate, model, and discuss areas of strengths and needed improvement. The child learns how to better communicate his or her needs to the caregiver, and the caregiver learns how to respond more favorably. Counselors interested in learning more about the VIG approach, training in VIG, and research supporting VIG as a treatment for RAD are encouraged to visit the website for The Association for Video Interaction Guidance uk at www.videointeractionguidance.net/reaearch.

Additional Treatment Options

Other therapeutic options to treat RAD include in-home treatment, psychoeducational group therapy, parent training, support groups for adoptive parents, and a combination of psychoeducation and psychotherapy. However, further research is required to qualify these as evidence-based modalities.

Resources:

The DDP Network provides resources for families and clinicians about Dyadic Developmental Psychotherapy. They also offer practitioner certification in DDP. www.ddpnetwork.org

Information about attachment disorders, as well as the DDP approach and related research articles, certified therapists, and videos, may be found at The Center for Family Development. www.center4familydevelop.com/therapy.htm

For more information on how to implement DDP, visit www.danielhughes.org

For more information about using VIG, see the Association for Video Interaction Guidance UK at www.Videointeractionguidance.net

Two-day trainings in VIG are available through: the Association for Video Interaction Guidance UK at www.videointeractionguidance.net/page-1815738; and, The Tavistock and Portman NHS at www.tavistockandportman.nhs.uk/training/courses/vido-interaction-guidance-cpd108

Psychopharmacotherapy

Currently, there are no medications specifically prescribed for RAD per se, although medications may be used to treat symptoms that co-occur with RAD. For example, anticonvulsant medications may be prescribed to treat poor impulse control and labile mood; antipsychotic medications to manage disorganized behavior; selective serotonin reuptake inhibitors (SSRIs) to address aggression; and, stimulants and some antidepressants to treat ADHD (Preston, O'Neal, & Talaga, 2013). Since RAD is a disorder unique to children, additional considerations should be carefully evaluated about how medications can affect children. For example, counselors should carefully monitor potential suicidal ideation among child clients prescribed antidepressant medication since children who take antidepressants may have an increased suicide risk (Preston et al., 2013). Similarly, counselors should watch for potential abuse or dependency among adolescents taking prescribed medications.

Resource:
Preston, J. D., O'Neal, J. H., & Talaga, M. C. (2013). Handbook of clinical psychopharmacology for therapists (7th ed.). Oakland, CA: New Harbinger.

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Publication Date: July, 2015