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Savanna Schaurer

Treatment of Reactive Attachment Disorder

Even with technological advancements in the medical field within the past decade, clinicians still debate over treatment methods for certain diseases. Cancer, for example, is an ongoing research topic that has no established cure; treatment plans are available to patients, but no guaranteed cure has been found. Often times for diseases like cancer, there are multiple options for treatment, but the most effective process is argued among researchers. Locating a cure for a disorder can get especially difficult when the mind and its mental processes are involved or when data is strictly refined to the observable behaviors that test subjects display. The treatment of a disorder found in children, Reactive Attachment Disorder (RAD), is an example of a currently-debated topic in research. RAD, in simple terms, is when a child fails to operate successfully in a social environment, and cannot respond appropriately to engagement with others. The treatment method for RAD is still being researched today, and although some experiments have been tested, they are rarely mentioned in research reports (Wimmer 353). Many theories about which treatment process is most successful for children with RAD exist, but because of the variety of factors from case to case, there is no ‘one size fits all’ process: “there are no established clinical guidelines for treatment of management of disorders of attachment” (Wimmer 353). Each child diagnosed with RAD

comes from a unique environment with a unique combination of factors influencing their childhood and relationships with caregivers. Despite the fact that children with RAD share similar behaviors, because of the vast variety of experiences among them treatment needs to become individualized for each case (Zilberstein and Messer 85). Many treatment processes have been tested and each process has proven to be successful to a degree. Some RAD therapies focus solely on assisting the caregivers, while others focus only on the child. It can be concluded that there is no one specific treatment because “addressing only one part of the system or targeting only one person in the system is not likely to lead to enduring change or benefit [for the child]” (Shaw and Paez 72). A more dynamic approach is needed to treat RAD, not an approach that is narrowed to one aspect of the child’s environment. The most effective treatment process for children with RAD involves establishing a secure environment by properly educating caregivers, rebuilding human connections, and providing consistency.

Before scrutinizing this treatment process for RAD, the examiner must be familiar with the disorder and the behaviors associated with it. The American Psychiatric Association (APA) defines RAD as “markedly disturbed and developmentally inappropriate social relatedness in most social contexts that begins before the age of five years, and that is persistent over time, and which is not purely a consequence of either social anxiety [...] or intellectual disability” (Rutter 535). In this definition, the APA included the fact that RAD is not caused by an intellectual

disability or other deficit. Rather, RAD is a consequence of factors present in the child's environment. The causes of RAD can be generalized into two overarching categories: maltreatment in early childhood and inadequate attachment to a reliable caregiver. The two branches of RAD, inhibited and disinhibited, display contrasting characteristics although caused by the same environmental factors. In inhibited RAD, the child tends to display characteristics of being "persistently withdrawn and have little or no interest in responding to others' attempts to initiate social interactions" (Haugaard and Hazan 157). These children avoid social contact and comfort from others. Whereas in disinhibited RAD the child is "non-selective or indiscriminate in their attachment behavior"; consequently, the child will readily cling to and be overly-affectionate towards strangers (Elovainio, et al. 53). These children believe that caregivers can be coaxed into providing affection, and as a result they exaggerate their condition and appear to be needy and dependent (Haugaard and Hazan 158). During diagnosis, clinicians need to determine which type of RAD the child exhibits, as this will aid in adjusting treatment as needed. Understanding RAD completely is a crucial step to take before moving on to the treatment plan of providing a secure environment.

The first step in providing a secure environment for a child suffering from RAD is educating caregivers on what RAD is and how the child behaves as a result. If the caregiver does not properly understand the disorder, then the child will not receive adequate care to help ease the effects. Education serves as the base of any

treatment process, as caregivers must be ready and prepared to address the range of behaviors that comes with RAD. Therapists are a crucial part of educating caregivers to provide a safe environment for the child. The provision of a safe environment “requires the clinician to be a keen observer of the child’s intricate emotional reactions and fully understand the complex dynamics behind them” (Shi 3). For example, when testing a treatment process, the therapist has to be able to identify behaviors exhibited by the child as signs of improvement or setback. Once the therapist can recognize and evaluate the child’s behaviors, then he or she will be able to explain those behaviors to the caregiver and provide further understanding. Explaining to the caregiver why the child is responding to stimuli, and not just how the child is responding will improve the caregiver’s understanding of RAD.

Another way to educate caregivers on the topic of RAD is to provide foster parent training sessions. In a case study involving Sam, a seventeen-year-old white male, part of the treatment process included engaging his foster parents in a series of behavioral parent training sessions for two hours every two weeks (Sheperis, et al. 82). The training the parents received varied, as some children may need to focus on one area of behavior while other children will need to focus on another area. For example, some children with RAD may require an Individualized Education Plan, and caregivers need to be aware of the child’s rights in a school setting in order to properly represent the child (Sheperis, et al. 82). Providing training to the caregivers will increase

understanding, so the child is closer to living in a secure environment.

Another way to further educate caregivers is to ensure that they are able to work through their own stress and dilemmas before moving on to help the child. A caregiver cannot adequately focus on improving the child if they are not able to first take care of personal issues. Therefore, by reducing stress placed on the caregiver, the child's needs will be met more often. In fact, one study showed that "positive changes in mothers' social support networks resulted in significant increases in secure attachment among their children" (Haugaard and Hazan 159). Improving the caregiver's social support networks with family, friends, and the community has a positive effect on the relationship with the child. Another method used to reduce the stress on caregivers is to provide them with mental health or addiction treatments if needed (Shaw and Paez 72). The child with RAD is a step closer to having a safe environment when the caregivers receive necessary therapies and become stabilized. All these processes to educate caregivers, ranging from training seminars to mental health therapies, can better prepare the caregivers to respond appropriately to the child's RAD behaviors.

Educated and prepared caregivers are just the first step in providing children with RAD a secure environment; the second step is to rebuild broken connections with the child. One way to rebuild child-caregiver attachment is to not focus on behavioral improvement in the child, but to focus on reestablishing human connections first (Shi 11). Part of the reason that children develop

RAD is due to the fact that attachment to their caregiver never took place, or the attachment that formed became broken. As infants grow and develop, they gradually begin to show preferences in caregivers, which indicates that attachment has taken place. The infant is confident that the specific person will consistently provide for them. If this primary caregiver becomes “inconsistent in responding to his or her infant’s signals for comfort” or the caregiver “consistently rebuffs the infant’s bids for comfort,” then the infant is likely to form some type of attachment disorder (Haugaard and Hazan 156). These patterns of inconsistent care and failure to satisfy the infant’s needs lead to broken attachments, which can in turn develop into RAD. Clinicians and caregivers cannot focus on improving behaviors of the child before first reestablishing a connection to the child. This step in the treatment is based knowing that attachment between the child and caregiver is the precursor for any desired improvements in the child (Shi 11). By reestablishing the attachment between the child and caregiver, the child will be more trusting and open to social relationships.

A suggested method to reestablish the child-caregiver attachment is to request the parents or caregivers to attend the child’s therapy sessions and become involved. This method was tested in a case study on a four-year-old boy, Tom, who was born to a crack-cocaine addict. Tom had been in six foster homes since the age of ten months, which resulted in no secure attachments formed to any of his caregivers (Shi 3). The foster family he was placed in at the time participated in therapies where the mother was able to join Tom by playing with toys beside him during the

sessions. The foster mother was able to develop a connection with Tom throughout the sessions by gradually showing him undivided attention and responding to what toys Tom was playing with. As the sessions proceeded, the mother eventually could hold Tom without him resisting attempts at affection. Although there were setbacks, such as Tom regressing to previous destructive behaviors, the overall result of including the mother in play therapies with Tom was positive in developing a connection between the two (Shi 10). Including caregivers in play therapies is just one way to rebuild the connection with the child.

Another approach to improving the child-caregiver attachment is through video interaction guidance (VIG). This process involves videotaping interactions between the caregiver and the child, and then showing the caregiver the positive exchanges that the child initiated. Through watching the video, the caregiver can use a version of self modelling to become more in tune with the child's cues for comfort or affection (Gorski and Minnis 386). Increased parental awareness to the child's bids for attention helps the caregiver recognize when the child is reaching out for comfort, and the caregiver is then able to improve the connection with the child. Results from a VIG study show positive progress in child-caregiver attachments: "The intervention group showed significant improvements in child attachment security and parental sensitivity, as well as a reduction in child disorganization" (Gorski and Minnis 386). By showing the caregiver examples of how to appropriately recognize their child's rare bids for attention, the caregiver is better able to reconnect with the child in a positive

way. In order to achieve a “state of felt security, infants need to be confident that a trusted person is consistently available to them” (Haugaard and Hazan 156). Once caregiver-child connections are put into place or improved, the child is then able to reestablish trust that someone will take care of their needs. This step in the treatment process will make the child feel more safe and secure in their environment; therefore, the effects of RAD will be minimized.

Once caregivers are educated of the child’s needs and the attachment is rebuilt, the third and final part of establishing a secure base for the child is providing consistency. Because studies have shown that a key cause of RAD is the absence of a consistent caregiver, it is logical that a consistent caregiver would reduce the effects of RAD in the child (Elovanio, et al. 53). Even if an educated caregiver is present, the child’s condition may worsen without the consistent implementation of proper care: “RAD children are likely to be re-traumatized and become even more distrustful if a secure-base care is offered and then pulled away prematurely or abruptly; or the care is unpredictable to start with” (Shi 12). Children need to be able to trust that someone is available to look out for them and provide for their needs consistently. If the caregiver starts to regress back to old habits of not responding to the child’s needs properly, then the bond between the caregiver and child is once again tarnished. Therefore, in order to keep the child-caregiver connection in place, a consistent and predictable relationship is required. It does not seem to matter who exactly the secure attachment is made to; however, what matters is that the individual is supportive of and is consistently available to the child

(Haugaard and Hazan 159). Providing consistency in the child's life and care will prevent setbacks from occurring.

Two ways that caregivers or foster parents can be sure to consistently provide for the child is to foster success and enhance self-esteem (Haugaard and Hazan 159). There are multiple ways to provide consistent feedback for the child, including congratulating him or her for obeying and reacting appropriately to social situations. Another option for caregivers to provide consistent reinforcement is through something called a "miracle question: 'Imagine you woke up and a miracle had happened and everything was the way you wanted it to be. What would you see? How would you feel? Who would notice?'" (Gorski and Minnis 387). Asking the child this type of question allows him or her to formulate their own idea of what proper behavior and what positive outcomes look like. Then the child can make a storyboard and act as a director that determines which acceptable behaviors are included in a stable environment. By allowing the child to recognize these positive attributes, the parent can use it to their advantage and consistently reinforce the child when positive behaviors are displayed. For example, in Tim's case study the mother used the miracle day scenario to positively shape Tim's behavior by reminding him of the 'miracle day' when he appeared regress to old behaviors. Tim was then able to successfully display newly acquired behaviors after the verbal reminder from his mother (Gorski and Minnis 388). By consistently reinforcing Tim's acceptable behaviors in reference to the "miracle day" question, his mother was able to provide consistent feedback for him to rely on. Consistency is crucial for

children with RAD to continue to improve. It was discovered in Sam's case study that part of his success was because of structure and consistency: "The latest foster home that Sam entered had more structure than others he had experienced. This was a big factor in his recent success because structure [...] equated with consistent reinforcement of appropriate behaviors" (Sheperis, et al. 86). This final step of providing consistency is key to developing a genuine and lasting secure environment for the child suffering from RAD.

RAD develops in children due to a variety of environmental factors, ranging from abuse or maltreatment to broken attachments with a caregiver. Because RAD is caused by a variety of factors in each child, no one specific treatment has been proven to work the best for every child. Treatment of RAD must be individualized according to each child and their specific situation and environment. There are many different theories proposed about how to go about providing the best individual treatment for each case. Some of these proposals include a focus on just correcting the child's behaviors, while others emphasize only assisting the caregivers. The most effective way to provide treatment for children with RAD involves a multi-stepped process, not a process with a singular focus on one aspect of the child's environment. This multi-stepped process has the ultimate goal of providing a secure environment for the child to function in. In order to achieve this, caregivers need to be educated on RAD and how it is exhibited in their child, the connections between the child and the caregiver need to be rebuilt, and the new environment

needs to be consistent. After this treatment process is completed, there should be “continued supportive therapy for family members to encourage continuation of the changes seen in the child” (Taylor 481). The family should be aware that simply putting this treatment into place is not enough; however, maintaining the secure base needs continued attention. A treatment process like this focuses on multiple dimensions of the child’s environment, and it works to improve several areas rather than focusing on only a single aspect of the child’s environment. Treating RAD by providing a secure environment can be a long process, but the benefits the child will receive as a result are worth the effort.

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