RAD

Reactive Attachment Disorder Basics

A child with reactive attachment disorder (RAD) has been subject to neglect or abuse or has another condition (i.e. Fetal Alcohol Syndrome (FAS)) and fails to establish the expected bond with his primary caregivers, resulting in irritability, sadness, fearfulness, and difficulty interacting with adults or peers (Child Mind Institute, 2021). This guide will help parents/caregivers understand how to spot reactive attachment disorder, and how it is diagnosed and treated.

RAD: What Is It?

It is healthy and expected for a child(ren) to become attached to their primary caregivers, those they look to for nurturing and soothing. Reactive attachment disorder (RAD) is a rare condition that occurs when infants and young children who are subject to extreme neglect or abuse or has another condition (i.e. Fetal Alcohol Syndrome) fail to establish that expected bond. A child with RAD, which is diagnosed from birth to 3 years of age, rarely seeks or responds to comfort when distressed, shows limited positive affect, and has unexplained episodes of irritability, sadness, or fearfulness in contact with caregivers (Child Mind Institute, 2021).

RAD has two sub-types: (a) inhibited RAD characterized by hyper-vigilance and emotional withdrawal and (b) disinhibited RAD characterized by indiscriminate friendliness, lack of social boundaries and difficulties negotiating social relationships (DSM-IV TR1). The DSM-5 separates these sub-types into two separate disorders. These are Disinhibited Social Engagement Disorder (D-SED), formerly Disinhibited RAD, and Reactive Attachment Disorder, formerly Inhibited RAD (DSM-5). D-SED is primarily characterized by indiscriminate friendliness towards strangers and Reactive Attachment Disorder is characterized by minimal social/emotional responsiveness and fearful behavior (Davidson et al., 2015).

RAD: What to Look For

Signs of RAD in infants and toddlers include a withdrawn appearance, a failure to smile, and a failure to react when parents or caregivers attempt to interact with them. For instance, a child with the disorder may not reach out when picked up or respond to a game of peekaboo. He may seem unaffected by the movements of others, and uninterested in watching others as they move about a room. Instead of seeking nurturing from a parent or caregiver, these children will attempt to nurture and soothe themselves. When distressed, they may calm down more quickly without the attention of an adult (Child Mind Institute, 2021)

RAD: Risk Factors

A child who has experienced abusive, neglectful, or otherwise problematic care is at risk for reactive attachment disorder. That said, the great majority of children who have been abused or neglected or who have been bounced around among multiple caretakers do not develop the disorder (Child Mind Institute, 2021).

RAD: Diagnosis

To be diagnosed with reactive attachment disorder a child must have a pattern of inhibited or withdrawn behavior towards caregivers, characterized by rarely or minimally turning to caregivers for comfort when distressed or responding to comfort when offered. The child must have experienced neglect or abuse in which the child's early caregivers failed to meet his physical or emotional needs, or repeated changes in caregivers that severely limited opportunities for the child to form selective attachments (Child Mind Institute, 2021).

Although not likely it is a possibility for RAD to develop if a child is securely attached to a caregiver but is left in pain unintentionally such as a medical condition that the caregiver I unable to comfort the child with (Child Mind Institute, 2021).

RAD: Treatment

Treatment for reactive attachment disorder usually involves both the child who has been diagnosed and his current caregivers. Treatment may include psychotherapy for the child, family therapy, parenting training, and special education services. Because RAD can be a painful and confusing experience for a child's caregiver, psychotherapy or counseling may be advisable for parents, too (Child Mind Institute, 2021).

There are tools that parents/caregivers can use to ease some of the stress for both themselves and their child. These ten (10) tools are (1) Sleep; (2) Simplify; (3) Structure; (4) Nutrition; (5) Six R's by Bruce Perry MD; (6) Brain Based Behavior Intervention (3BI); (7) Loving Leadership; (8) Resolution of a Childs Trauma; (9) Feeling of Safety; (10) Touch. d

- Top Ten Tools

- Sleep
  - Healthy habits at bedtime = healthier brain
  - Same bedtime every night
  - 12 hours for 1-13 years old
  - 9.5 hours 14-21
  - 8 hours 21 and up
  - Complete darkness
  - Check for calcium, exercise, temperature
- Simplify
  - Clear the Calendar (parents and child)
  - Child's room
    - 7 sets clothing
    - 3-4 books
    - Stuffed animals
  - Reduce/Remove
    - Input
    - Violence
    - Disrespect
    - Electronics
      - TV
      - Computer
      - Xbox
      - Gameboy
    - Noise
      - Add times of silence
    - News
  - 68% went from clinically dysfunctional to clinically functional in 4 mo. No meds
  - 36.8% increase in academic & cognitive ability
- Structure
  - Meals and bedtime on time same tie
  - Work and play
  - Activities for work and play are directed (no time wandering looking for something to do)
  - Give and take in healthy balance
- Nutrition
  - Food fuels the body and the brain (garbage in/garbage out)
  - We crave simple carbs when stressed
    - Pasta
    - Chips
    - Sugar
  - Avoid the "activators"

        - MSG (monosodium glutamate)
        - Dyes Red 40 Yellow 4&5 Blue 5
        - Nitrates
        - Caffeine
    - Neurotransmitters are made from parts of protein (serotonin, dopamine, etc.)
    - Neurotransmitters are made in the gut
- Six R's by Bruce Perry MD
    - Discovered that doing 6 R's healed the brain from the brainstem up towards the cortex
    - Top parts of the brain are easier to heal than the bottom
        - Respectful
        - Rewarding
        - Rhythmic
        - Relational
        - Repetitive
        - Relevant
    - Must be sustained for 7 min 5x per day
    - Key to working with these children is to be proactive in keeping them regulated
    - Watch arousal level (eyes, ears, coloring, breath)
    - Activity Ideas
        - Drumming
        - Go for a walk, run, skip, gallop
        - Boomwhackers
        - Hand clapping games
        - Skipping ropes
        - Ping pong
        - Badminton
        - Dancing
        - Bouncing a ball
        - Playing catch with balls or beanbags
- Brain Based Behavior Intervention (3BI)
    - Behavior Modification does not work because of cause-and-effect dysfunction. Must use brain based:
        - Respect
        - Responsible
        - Fun to be with
    - When a child's behavior is disrespectful etc., adult selects brain shifter (sit 30 sec/5 jumps/5 min mini tramp)
    - When child has shifted, he is hugged/high fived and asked, "what happened?"

        - Hugged/high fived “good job telling the truth”
        - “What can you do to fix it/clean it/make it up?” (an act of kindness)
        - Hugged “Good plan!”
        - Not for punishment. It is to help the brain shift gears and the child to show that he has re-gained self-control. Learning cannot happen when the survival part of the brain is hot.
        - These activities will help the brain to shift
        - When the child has shifted
            - Sitting will be still, straight, and silent or jumping jacks
            - Ask the question, “what happened?”
            - Child should answer with an “I” statement
            - “Good job telling the truth (give high five and smiling eyes!)
            - No lectures!
            - Ask, “What are you going to do about it?”
            - Plan for restitution /repair/cleanup (community service)
            - Child should answer, “May I please…”
            - Older teens write answers to the following questions:
                - What happened?
                - What was I feeling?
                - How did I handle it?
                - How did it work out for me?
                - How am I going to handle it in the future?
    - Loving Leadership
        - One adult whose priority is the child’s healing
        - A decision make who meets child’s needs
        - Says “yes” to child’s needs
        - Says “no” to wants until limits are accepted
    - Resolution of a Child’s Trauma
        - A great therapist
            - Release and resolve the past with EMDR
            - Put parent and child together in a healthier way
            - Teach child to use words instead of actions
            - Support Parents!!!
        - An untrained therapist
            - Meets with the child separate
            - Allows child’s pathology to control session
            - Doubts parents
    - Feeling of SAFETY
        - Emotional Safety
            - Rejection/Acceptance
            - Honest person they can trust
        - Physical Safety

        - No room sharing
        - Other child intimidating/hurting
        - Angry parents scare child and activate the wrong area of the brain
        - Action not anger
    - Tests for Trust
        - Children with trust issues will use these to assess leadership:
            - Can I interrupt you?
            - Can I get you to repeat yourself?
            - Can I get you to believe?
            - Can I steal from you?
            - Can I hurt animals or another child?
- Touch
    - 12 hugs everyday
    - Snuggle time
    - The heart-to-heart connection
        - Eye contact
        - Touch
        - Movement
        - Smiles
        - Something sweet

(Lorman Education Services, 2021)

RAD: Risk For Other Disorders

Children who have experienced neglect in caregiving may also experience developmental delays and delays in physical growth. Older children may be at risk for eating disorders, anger management problems, depression, anxiety, difficulties in school, and drug and alcohol abuse (Child Mind Institute, 2021).

RAD: Professional Boundaries

It is critical that there are professional boundaries established between a provider and a child diagnosed with RAD. Physical connection such as fist bumps and high fives are ways that fulfill the need for affection & celebration. Hugs must be reserved for the primary caregiver to allow room for emotional bonding with the caregiver not the provider. Maintaining these types of boundaries by allowing affection, such as hugging, to strictly be reserved for the primary caregiver(s) (e.g. parents) encourages the needed bond between them. Providers must support this. It is common for children with RAD to be manipulative, so providers should be aware of the necessary boundaries that must be established at the immediate conception of the relationship (Child Mind Institute, 2021).

Citations

Child Mind Institute. (2021, March 22). Reactive Attachment Disorder Basics. Child Mind Institute. https://childmind.org/guide/reactive-attachment-disorder/.

Davidson, C., O'Hare, A., Mactaggart, F., Green, J., Young, D., Gillberg, C., & Minnis, H. (2015). Social relationship difficulties in autism and reactive attachment disorder: Improving diagnostic validity through structured assessment. Research in Developmental Disabilities, 40, 63–72. https://doi.org/10.1016/j.ridd.2015.01.007

Lorman Education Services (2021, April 30). Reactive Attachment Disorder Online Training. https://www.lorman.com/