



Reactive Attachment Disorder (RAD) Clinical Guidelines

In collaboration with FBH Partners' providers, MHCBBC, JCMH and the IPN

DSM-IV-TR Diagnostic Code: 313.89

Screening/diagnosis guidelines:

1. A **diagnosis** of RAD requires the following: 1) disturbed and developmentally inappropriate social relationships before age 5; 2) failure of the child to respond to or initiate social interactions, or being inappropriately friendly and familiar with strangers; and 3) failure of early caregivers to meet emotional needs for comfort and affection, to attend to the child's physical needs, or repeated changes in primary caregiver.
2. The **assessment** of this disorder should include observation of child and caregiver interactions in numerous contexts, a review of attachment behaviors with these caregivers, identifying whether the current caregivers are the adoptive or birth parents, and observations of the child's behavior with unfamiliar adults. In addition, an assessment of abuse (physical or sexual) and/or neglect or maltreatment should be conducted.
3. Results of a thorough physical exam should be requested and reviewed to rule out **medical issues**. Children who experience extreme neglect may show signs of growth delay, physical abuse, malnutrition, vitamin deficiencies, or infectious diseases.
4. RAD is divided into **two types**, inhibited and disinhibited. While some children have signs and symptoms of just one type, many children have both. Signs and symptoms of the inhibited type include: 1) resisting affection and comfort from caregivers; 2) avoiding both physical and eye contact; 3) preferring to play alone; and 4) appearing to be on guard or wary.

The RAD disinhibited type includes those children who demonstrate inappropriate and indiscriminant attachment behavior, to virtually everyone, including strangers. Signs and symptoms vary according to age and developmental stage and may include: 1) readily going to strangers, rather than showing stranger anxiety; 2) exaggerating needs for help doing tasks; 3) inappropriately childish behavior; and 4) appearing anxious.

5. **Differential diagnosis** should include mental retardation, autistic disorder and other pervasive developmental disorders, anxiety spectrum disorders, language disorders, depression, posttraumatic stress disorder, attention-deficit/hyperactivity disorder, conduct disorder and oppositional defiant disorder. These can also co-occur with RAD.
6. The same risk conditions that lead to RAD, can also lead to secondary problems such as: anxiety spectrum disorders, depression, posttraumatic stress disorder, conduct disorder and oppositional defiant disorder.

Treatment Guidelines:

1. The **primary goal** of treatment is to help ensure that the child has a safe and stable living environment in which the child is safe to explore trusting relationships.
2. Treatment **goals and approaches** should be based on the developmental age of the child. The child's developmental age may be different from their chronological age.
3. Treatment commonly involves **family and individual psychotherapy** for both the child and caregiver/family. One of the most important factors for successful treatment is for the therapist to advocate for consistent and emotionally available attachment figures.
4. Ongoing **collaboration** with parents/caregivers, teachers and medical providers is an essential component of treatment for children and adolescents with RAD. The clinician needs to provide support and education about RAD to the primary caregivers and help to create consistency between environments.
5. **Information** should be provided to parents/caregivers and teachers about the chronic nature of RAD and its effect on learning, behavior, social skills and family functioning.
6. **Support for parents/caregivers** is important to the success of treatment. This may include individual therapy and/or couples therapy. Support groups, such as parenting support groups, can also be helpful to connect with other families facing similar issues for support, to mutually learn coping skills, and to help in normalizing their experiences.
7. Teaching **parenting skills** can help improve the relationship with the child and help develop attachment. Treatment may also include education on parenting styles, and reading the verbal and non-verbal cues of the child.
8. Families of children who meet criteria for RAD and who display aggressive and oppositional behavior may require **adjunctive treatments** such as parent effectiveness training, multisystemic therapy and teaching caregivers about redirecting behaviors and utilizing natural consequences.
9. The use of **alternative treatments** such as holding therapies and/or "rebirthing" techniques has been denounced by research and there is no scientific evidence to support the effectiveness of such interventions. The use of such techniques has been associated with serious injury and even death.
10. **Medication:** There is no medication to treat RAD itself. However, medications may be used to treat associated symptoms.

* Adapted from the American Academy of Child & Adolescent Psychiatry (2005). *Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood*. 44 (24), NGC:004221.