Reactive Attachment Disorder:

Considerations for School Counselors

by

Diane Hausler

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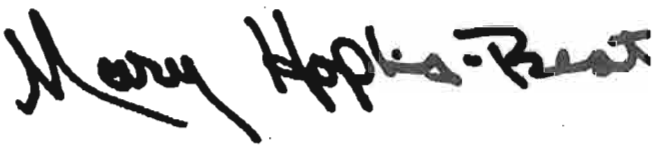

Mary Hopkins-Best

The Graduate School

University of Wisconsin-Stout

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The Graduate School
University of Wisconsin-Stout
Menomonie, WI

Author: **Hausler, Diane L.**

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Abstract

The study of attachment between caregivers and infants by Bowlby, Ainsworth, and other researchers has laid the foundation for the creation of Reactive Attachment Disorder as a medically diagnosable disorder. While this diagnosis exists there clearly lacks consistency among current researchers as to the causes, diagnosis, and treatment of this disorder. The study of RAD is in its infancy and requires a great deal of research to be conducted in the areas of assessment/diagnosis, treatment, implications for students in the school system, and long-term course of the disorder into adulthood.

School counselors will be challenged to be the "expert" in the school systems. This will include educating school personnel and parents on the causes, symptoms, diagnosis, and treatment of RAD as well as collaborating with community agencies and social services to provide preventative interventions in the communities with families.

The Graduate School
University of Wisconsin Stout
Menomonie, WI

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Chapter I: Introduction

Attachment disorder, also known as reactive attachment disorder (RAD), and characterized by adverse behavioral problems is a problem known to social workers and professionals in the adoption field. This disorder is rooted in the theory that the attachments developed from the time we are born can greatly affect our future behaviors and relationships. Attachment disorders are not only a concern for professionals in the social work and mental health fields, but it is an issue facing our education system. Teachers and school counselors are being challenged to assist in the development of interventions with students coming to school with attachment issues.

The relationship between the caregiver and infant has been studied extensively and is said to have a profound impact on the emotional development of a child. The Association for the Treatment and Training in Attachment of Children (ATTACh) (2008) defines attachment as a "reciprocal process by which an emotional connection develops between an infant and his/her primary caregiver" (Attachment section, para.1). Secure attachment occurs when the needs of the child are met repeatedly by a consistent caregiver. When a child is neglected, abused, or has multiple caregivers, the chances of developing an insecure attachment are greater and can lead to an eventual diagnosis of RAD.

The DSM-IV-TR (2000) defines the following criteria for a clinical diagnosis of RAD:

> A.) Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years as evidence by: B.) The disturbance in Criterion A is not accounted for solely by developmental delay and does not meet criteria for a pervasive developmental disorder. C.) Pathogenic care as evidenced by a least one of the following: 1. Persistent disregard of the child's basic emotional needs for comfort,

> stimulation, and affection; 2. Persistent disregard of the child's basic physical needs; and 3. Repeated changes of primary caregiver that prevent formation of stable attachments (American Psychiatric Association ([APA]), 2000, p. 129).

Children being diagnosed with RAD have experienced profound neglect, abuse, or repeated changes in caregivers (Schwartz & Davis, 2006, p.472). As a result of their early caretaking, children with RAD struggle to develop the necessary skills to create new healthy relationships with caring adults. Hall and Geher (2003) report that; "RAD affects and disrupts more than just the individual with the disorder. Family members find they are unable to deal with the problems of their children with RAD and are often unable to protect the other children in the home from the dangerous actions of a sibling with RAD" (p.149). Additionally, children diagnosed with RAD are often at a higher risk of failed placements within the adoption and the foster care systems.

Children diagnosed with RAD also provide significant challenges for educators and school counselors whose work is grounded and motivated in creating and maintaining relationships with students and collaborating with families.

> Schools face the dilemma of how to manage the behavior problems of children with RAD and of how to educate them. Children with RAD tend to act out, bully, scare, and harm other children at school. Furthermore, these children often do not fit into either regular or special education classrooms. (Hall & Geher, 2003, p. 149).

Children diagnosed with RAD may begin attending school before they are developmentally or emotionally ready to function in the school learning environment. RAD diagnosed children struggle with regulating their emotions and behaviors when it comes to forming new relationships with teachers and peers (Schwartz & Davis, 2006, p.473). Raver and Zigler (1997)

indicated teachers report that the "emotional, social, and behavioral adjustment to school is just as important as cognitive and academic preparation" (cited in Schwartz & Davis, 2006, p. 475). Children in our schools who struggle, with attention, following directions, getting along with others, and controlling negative emotions, have a tendency to do poorly socially and academically (Ladd, Kochenderfer, & Coleman, 1997). The treatment of RAD is also an area of concern for school personnel, especially school counselors, who will likely have these students on their case load. Complicating the issue is that many of the currently used treatments for RAD have not been empirically researched, are controversial in nature, and focus primarily on developing a strong attachment with the caregiver. Additionally, some treatments require specialized training and protocols that cannot be provided within a school setting.

In summary, there is research regarding causes and the, diagnosis of RAD is in its infancy, and treatment of attachment disorder is both controversial and poorly researched, but one thing is certain; children with attachment disorders are in our education system and school personnel including school counselors need to be more educated on how to best help these children succeed in the school environment.

Statement of the Problem

According to Parker and Forrest (1993), "If the proper bonding and subsequent attachment, usually between mother and child, does not occur, the child develops mistrust and deep-seated rage" (para.1). For school personnel, working with children diagnosed with RAD can be very difficult. School counselors need to better understand the diagnosis, treatment, and management of students with attachment disorders in order to assist teachers and parents in developing strategies and interventions that can help the child succeed in school.

Purpose of the Study

The purpose of this study is to conduct a synthesis and analysis of literature on the history, theoretical framework, causes, diagnosis and treatment of RAD, followed by an analysis of the implications of that research for children diagnosed with RAD in a school setting and the role of school counselors in serving children diagnosed with RAD.

Research Questions

There are three research questions this study will attempt to answer. They are:

1. What are the behaviors associated with RAD?
2. What are current practices for assessment and diagnosis of RAD?
3. What are the current available treatments for RAD?

Definition of Terms

The following terms need to be defined for clarity of understanding.

Attachment – "Attachment is reciprocal process by which an emotional connection develops between an infant and his/her primary caregiver. It influences the child's physical, neurological, cognitive and psychological development. It becomes the basis for development of basic trust or mistrust, and shapes how the child will relate to the world, learn, and form relationships throughout life" (ATTACH, 2008, para.1)

Attachment therapy –Treatment techniques which include; holding, re-birthing, rage-reduction, re-parenting, and attachment parenting. These therapies are often conducted at private institutions that claim to be experts of *attachment disorder* and *attachment therapies*.

Reactive attachment disorder – "A mental health disorder in which markedly disturbed and developmentally inappropriate social relatedness is noted in most contexts and that begins before five years of age in association with grossly pathological care" (Cain, 2006, p. 194).

Chapter II: Literature Review

Reactive attachment disorder is a complex topic and one in need of further research and attention. Developments have been made in the field however progress has in many ways polarized traditional and non-traditional approaches to assessment and treatment.

This chapter will provide a review of the literature regarding Reactive Attachment Disorder (RAD). Topics to be covered include: attachment theory and the early study of attachment disorders, identification of RAD as a type of mental disorder, behaviors associated with RAD, intervention and treatments.

Attachment Theory and the Early Study of Attachment Disorders

The study of attachment and its effect on child development has been in development since the 1930's. Two of the most notable contributors are John Bowlby and Mary Ainsworth whose contributions will be discussed further in the following sections.

Contributions of John Bowlby. John Bowlby, trained in what now would be called developmental psychology has been referred to as the "father of attachment" according to Parker and Forrest (1993). During Bowlby's early career, which spanned from1928 to 1940, he spent time volunteering at a school for maladjusted children. In his time at the school he encountered two children that were the likely impetus for his future career path as a child psychiatrist (Bretherton, 1992). One boy was a teenager who was very isolated, and appeared to lack affection toward other people; the other seemed to be attached at the hip to Bowlby (Bretherton, 1992). After working with these boys Bowlby began training at the British Psychoanalytic Institute where he was exposed to ideas rooted in the theory of psychodynamics. Bowlby disagreed with the prevailing belief that "children's emotional problems are almost entirely due

to fantasies generated from internal conflict between aggressive and libidinal drives rather than to events in the external world" (Bretherton, 1993, p. 760).

Bowlby's first empirical study regarding the theory of attachment was based on 44 sets of case notes from the London Child Guidance Clinic (Bretherton, 1993). From review of the case notes Bowlby saw a correlation between the behaviors and early maternal deprivation and separation (Bretherton, 1993). Bowlby's theory of attachment continued to evolve into the 1940's when he began to search through ethology (the study of the behavior of animals) findings for new concepts that could be applied human behavior. It was during this time that he became intrigued by Konrad Lorenz's paper on imprinting with geese (Bretherton, 1993). In 1958 Bowlby presented the first of three papers regarding attachment theory to the British Psychoanalytic Society. "The Nature of the Child's Tie to His Mother" released in 1958 was followed by "Separation Anxiety" in 1959. Bowlby's third paper was "Grief and Mourning in Infancy and Early Childhood" released in 1960 (Bretherton, 1993).

Wallach and Caulfield (1998) describe Bowlby's theory as an "explanation of how parent-infant interactions shape their adaptive behavioral capacities in response to emotional and social experiences" (p. 125-126). Bowlby's theory assumes that the parent-infant relationship influences how infants learn to organize their behaviors.

Attachment theory is based on the assumption that human infants instinctively want to maintain close proximity with their caregiver. When the infant is faced with a stressful or uncertain situation, the ability to find his/her caregiver quickly provides comfort and reassurance. An example of this is when an infant experiences hunger pains, the infant cries out. The caregiver responds by attending to the child and providing them with nourishment. When this process happens repeatedly and in several situations of discomfort, a secure healthy attachment is

formed between the infant and the caregiver. Attachment is also evident when the infant is faced with a situation where he/she is forced to separate from the person with whom they have formed an attachment. An infant with a growing attachment will resist the separation and become upset (Wallach & Caulfield, 1998). "Repeated experiences become encoded in implicit memory as expectations and then as mental models or schemata of attachment, which serve to help the child feel an internal sense of what John Bowlby called a "secure base" in the world (Siegel, 1999, p. 67).

Contributions of Mary Ainsworth. Mary Ainsworth attended the University of Toronto where she was introduced to security theory (Bretherton, 1993). According to Bretherton (1993), security theory states that "infants and young children need to develop a secure dependence on parents before launching out into unfamiliar situations" (p. 760). Subsequently Ainsworth completed her dissertation entitled "An Evaluation of Adjustment Based on the Concept of Security" (Bretherton, 1993). Mary Ainsworth began to work with Bowlby researching the "effect on personality development of separation from the mother in early childhood" (Bretherton, 1993, p. 761). In 1953 Ainsworth began collecting observational data with infants and mothers in Uganda; this study is now seen as the first empirical study of attachment. Ainsworth followed up the Uganda study with The Baltimore Project study. This study based on naturalistic observations looked at 26 Baltimore families. Ainsworth observed the mother and infant in their homes for 4 hours at a time on18 different days (Bretherton, 1993). Ainsworth began to see differences in the mother's response to the child and how attached the infant became.

The Baltimore Project paved way for the most well known contribution of Mary Ainsworth, the "strange situation" assessment technique. In 1969 Ainsworth and colleague

Wittig developed a standardized procedure for assessing attachment. This procedure evaluates the individual differences in parent-child attachment through a series of short separations and reunions with the caregiver. (Wallach & Caulfield, 1998). This procedure is done in an unfamiliar room and also involves a strange adult entering and leaving the room. This person helps to assess the "child's management of distress and his/her use of the parent as a secure base" (Wallach & Caulfield, 1998, p. 126)

As a result of the "strange situation" technique three original categories of attachment were identified with a fourth to be identified after further research was done with at-risk infants (Wallach & Caulfield, 1998). These include: secure attachment, avoidant attachment, resistant attachment, and disorganized/disoriented attachment (Wallach & Caulfield, 1998).

Securely attached infants get upset when they are not in the presence of their caregiver, and are especially happy to see them when they return. Ainsworth hypothesized that infants develop a secure attachment when the caregiver is especially sensitive to the needs of the infant (Wallach & Caulfield, 1998).

Children who have developed an avoidant attachment do not show distress when the caregiver leaves the room, and react the same way when the stranger enters the room. When the caregiver re-enters the room, they tend to avoid them. This type of attachment is common when the caregiver is rejecting of the infants needs and affection (Wallach & Caulfield, 1998).

Resistant attachment is characterized by an infant who, before the separation, wants to be very close to the caregiver but when he/she is reunited, the infant begins to resist the caregiver. This can be done by hitting, pushing, or resisting or crying when picked up. Avoidant attachment is common when the caregiver is inconsistently meeting the needs of the infant (Wallach & Caulfield, 1998).

The last category is disorganized/disoriented attachment. This type of attachment is characterized by a high level of insecurity where the infant shows signs of confusion when reunited with the caregiver. According to Wallach and Caulfield (1998) disorganized/disoriented attachment is most likely to occur in situations where the caregiver is under great financial strain, or has been diagnosed with an untreated mental illness such as depression. It is also likely in situations of neglect and abuse.

The contributions of Bowlby and Ainsworth have created a solid foundation for the study of attachment between caregivers and infants. Further research has led to the development of a medical diagnosis of Reactive Attachment Disorder (RAD)

Identification of RAD as a Type of Mental Disorder

The study of early attachment with infants and caregivers has led researchers to look at the effect attachment has on the emotional, behavioral, and social development of children and adolescents. Subsequent research has allowed for the categorization and development of diagnostic criteria for RAD.

The American Psychiatric Association (APA) released a position statement defining RAD and its causes. Additionally, they provide a statement about appropriate treatment of RAD. According to this position statement RAD is a:

> . . . complex psychiatric condition that affects a small number of children. It is characterized by problems with the formation of emotional attachments to others that are present before age 5. . . The child with RAD may appear detached, unresponsive, inhibited or reluctant to engage in age-appropriate social interactions (American Psychiatric Association ([APA]), 2002, para.1).

The APA attributes RAD to "severe disruptions in their early relationships" (APA, 2002, para.2). Many of the children who have experienced these early disruptions of attachment are victims of abuse (physical, emotional, or sexual). They may also have experienced isolation, or neglect. Children who have experienced traumatic losses or multiple caregivers are also at risk to develop RAD. (APA, 2002).

According to the APA (2002) diagnosis and treatment for RAD is complex and should be taken very seriously. The association recommends that a comprehensive evaluation be completed to rule out other disorders especially Pervasive Development Disorders as a cause for the child's behavior. The APA does not provide specific treatment options, but stresses that an "individualized treatment plan" (APA, 2002, para.4), will have the most benefit for the child. It is also clear that the APA does not endorse the use of experimental treatments such as coercive holding therapies, and re-birthing techniques because the success of these interventions is not empirically based (APA, 2002)

Diagnostic criteria for the medical diagnosis of RAD come from the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition. A text revision was released in 2000. The following is the criteria for a clinical diagnosis of RAD:

> A.) Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5. B.) The disturbance in Criterion A is not accounted for solely by developmental delay and does not meet criteria for a pervasive developmental disorder. C.) Pathogenic care as evidenced by a least one of the following: 1. Persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection; 2. Persistent disregard of the child's basic physical needs; and 3. Repeated changes of

primary caregiver that prevent formation of stable attachments (American Psychiatric Association ([APA]), 2000, p. 129).

The DSM-IV-TR further breaks RAD into two subtypes defined by the predominant type of disturbance in social relatedness; inhibited type and disinhibited type. Inhibited RAD is characterized by; "emotionally constricted and socially withdrawn behavior during interactions with others" (Boris et al., 2003, p. 8). Children with inhibited RAD do not consistently seek comfort from others when they are in distress. They may also have trouble regulating their emotions (Boris et al., 2003, p. 8). Inhibited pattern of RAD has been identified in children with "histories of maltreatment and in children who are being reared in institution" (Boris et al., 2003, p. 8).

Disinhibited RAD is characterized by children who "may approach unfamiliar adults without any reticence, seek or accept comfort from unfamiliar adults, protest separation from total strangers, or wander away from their caregiver without checking back" (Boris et al., 2003, p. 9). Children with a history of maltreatment, or who have been institutionalized are at risk for this diagnosis (Boris et al., 2003, p. 9). Specific behaviors relating to the two subtypes will be discussed further later in this chapter.

The DSM-IV-TR also emphasizes the importance of a differential diagnosis from other conditions such as: Mental Retardation, Pervasive Developmental Disorders including Autism, Social Phobia, Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, and Oppositional Defiant Disorder. According to the DSM-IV-TR the course of RAD is likely to vary depending on the severity and duration of deprivation. Improvement or remission may be possible with an intervention of a supportive environment however otherwise the course is continuous and

"indiscriminate sociability may persist even after the child has developed selective attachments" (APA, 2000, p. 129).

The APA has recognized RAD as a diagnosable disorder since the release of the DSM-III however research in this area seems to be lacking especially when it comes to the best way to appropriately diagnose the disorder. Critics of the DSM-IV-TR diagnostic criteria oppose the narrowness and vagueness citing that; "Current criteria for the attachment disorders set out by DSM-IV and ICD-10 are not adequate for guiding clinical research or practice" (O'Connor & Zeanah, 2003, p. 234). This inadequacy has led some in the field to propose alternative criteria for *attachment disorders* based on their clinical experiences and observations. Chaffin et al. (2006) states;

> In the absence of consensual and officially recognized diagnostic criteria, the omnibus term *attachment disorder* has been increasingly used by some clinicians to refer to a broader set of children whose behavior is affected by lack of a primary attachment figure, a seriously unhealthy attachment relationship with a primary caregiver, or a disrupted attachment relationship" (Chaffin et al., 2006, p. 81).

One alternative set of criteria is suggested by Zeanah and Boris (2000). Zeanah and Boris' criteria for *disorders of attachment* are based out of their developmental attachment research. This alternative approach involves three broad types of attachment disorders: "disorders of nonattachment, which are similar to the DSM-IV and ICD-10 disorders, secure-base distortions, in which the child has a seriously unhealthy attachment relationship with the particular caregiver, and disrupted attachment disorder, in which the child reacts to the loss of an attachment relationship" (p. 358). In their study using a clinically referred sample of infants and toddlers they found these alternative criteria more reliable than the DSM-IV criteria (Zeanah &

Boris, 2000, p.358). The assessment used by Zeanah and Boris is focused on the child's relationship with attachment figures rather than any characteristic of the individual child. Focus is given to aspects of the relationship that are most salient for attachment which include: "caregiver emotional availability and child emotion regulation, caregiver nurturance-warmth-sensitivity and child trust-security, caregiver protection and child vigilance-self-protection, and caregiver provision of comfort and child comfort seeking" (Zeanah & Boris, 2000, p.365).

Further complicating the issue of diagnosis of RAD is the lack of a widely agreed upon assessment protocol or tool. A deficit in this area leaves open the possibility for misdiagnosis. Chaffin et al. (2006) states that; "No generally accepted standardized tools for assessing RAD exist, and several interview procedures in the literature misdiagnose inappropriately high numbers of children as having RAD who, in fact appear to have only mild to moderate symptoms" (p. 80). Additionally research shows that many other diagnosable disorders share some characteristics with RAD making differential diagnosis a critical but difficult piece in the accurate diagnosis of RAD. These disorders as mentioned earlier include; mental retardation, pervasive developmental disorders, autism, attention deficit disorders, oppositional defiant disorder, conduct disorder, and antisocial personality disorder (Sheperis et al., 2003, p. 294). Sheperis et al., (2003) recommend the following key components to adequately diagnosing RAD:

> (a) differentiating the cognitive and lingual portion of the disorder adequately from other developmental disorders; (b) noting the behavioral portions, despite their tendencies to overlap other conduct type disorders; (c) paying particular attention to the assumed origin of the disorder as it relates to symptomotology; and (d) placing special emphasis on careful consideration of these criteria when making the diagnosis (p. 294-295).

While research shows that there is no widely agreed upon standardized assessment for diagnosis, some researchers have attempted to develop and test procedures to help standardize the assessment and diagnosis by evaluating current assessment scales and other diagnostic practices such as interviews, and behavioral observations.

Sheperis et al., (2003) in their study propose a battery of semi-structured interviews, global assessment scales, attachment-specific scales, and behavioral observations. They identified several procedures and instruments that have been helpful in diagnosing RAD and to differentiate it from other behavioral disorders. Specifically they found the following scales to be helpful in providing identification of behavioral problems; Child Behavior Checklist (CBC), Behavior Assessment System for Children (BASC), Eyberg Child Behavior Inventory (ECBI), and Sutter-Eyberg Student Behavior Inventory. After identifying specific behavioral problems Sheperis et al., (2003) use the Randolph Attachment Disorder Questionnaire, and the Reactive Attachment Disorder Questionnaire to gather information specific to attachment related behaviors. Following a comprehensive assessment using various measures, Sheperis et al., (2003) move forward with the use of direct behavioral observations. These come in the form of structured and semi-structured interviews, behavioral rating scales, and standardize tests. Through this process they gather extensive psychosocial history that includes; parental history, medical history, developmental history, mental health history, school history, and disciplinary practices.

These researchers have found this comprehensive evaluation to be helpful in their clinic for diagnosing RAD but recognize the time and resources it takes to do this sort of evaluation and realize not all families will have the resources available to them. Additionally they state that more research needs to be done to standardize the process for assessing RAD and that "mental

health counselors are ethically, legally and professionally obligated to conduct thorough evaluations that are multi-modal and multi-informant in nature in order to effectively provide differential diagnosis, evaluate comorbidity, and establish comprehensive treatment plans" (Sheperis et al., 2003, p. 309).

Given the complicated and highly controversial nature of assessment and diagnosis of RAD. O'Connor and Zeanah (2003) provide seven conclusions and recommendations concerning assessment. First, the current criteria described by the DSM-IV are not adequate for guiding clinical research or practice. Secondly, multiple methods of assessment are needed and information from multiple sources should be brought together creating comprehensive assessment. Their third conclusion addresses the important role that observations play in the assessment of RAD. Particular attention should be given to looking at the behaviors elicited with familiar caregivers compared to behaviors with strangers. Additionally O'Connor and Zeanah (2003) state that "questionnaire methods may be least informative method of assessment" (p. 234). The fourth conclusion refers to the usage of the Strange Situation as a useful assessment methodology, but recognizes the conventional coding criteria as insufficient and possibly misleading. O'Connor and Zeanah (2003) in their fifth recommendation recognize the importance for assessing the quality of the child-caregiver attachment relationship, and call for more research in this area because as of this time no valid measurements are available. The sixth recommendation states that assessment should include a "detailed investigation of co-occurring behavioral and emotional problems, cognitive and neuropsychological functioning, and social relationships, especially with peers" (p. 234). The final conclusion addresses something that is apparent throughout attachment research and literature and that is that "behavioral definitions of

attachment disorder appear to be adequate for younger children, but may be inadequate for children of primary school age or older" (O'Connor & Zeanah, 2003, p. 234).

As discussed above accurate diagnosis of RAD is essential and will need to be made by a clinical psychologist. Although a school counselor or school psychologist will not provide a diagnosis of RAD it is important to note that a school system can evaluate and diagnose a child with Emotional Behavioral Disorder (EBD), which allows them to qualify for services under the Individuals with Disabilities Education Improvement Act (IDEA). This diagnosis would allow a child to receive services and interventions without actually receiving a diagnosis of RAD. Davis, Kruczek, and McIntosh (2006) support interventions for children diagnosed with EBD or other psychopathology in the schools. Specifically they state that:

> School personnel and school mental health professionals in particular have the advantage of (a) being able to observe the behavioral manifestation of emotional disturbance within one of the child's main ecological systems and (b) being able to directly intervene with the student in that system (p. 414).

Empirical research needs to continue in the area of assessment and diagnosis of RAD in order for clinicians and school personnel to be successful in properly identifying and diagnosing RAD. Proper identification and diagnosis is also essential to move forward in developing and implementing successful interventions and treatments.

Behaviors Associated with RAD

The diagnosis of RAD according to the DSM-IV-TR is characterized by the presence of "markedly disturbed and developmentally inappropriate social relatedness in most contexts beginning before age 5 years and is associated with grossly pathogenic care" (American Psychiatric Association ([APA]), 2000, p. 127). This diagnosis continues to be argued by

different schools of thought regarding attachment disorder, its causes, diagnosis, symptoms, behaviors, and treatment. While a school counselor is in no way shape or form qualified to provide a child with a diagnosis, the counselor will be challenged to respond and intervene with the child when behaviors manifest in the classroom, lunch room, hallway, and playground. For this reason school counselors must be familiar with research relating to behaviors of RAD that manifest in the school. Understanding and recognizing the behaviors indicating attachment problems is also an essential piece for school personnel to make appropriate referrals to outside agencies for assessment and treatment.

The behaviors associated with RAD are widely talked about but rarely fully agreed upon. As stated earlier the clinical diagnosis of RAD breaks it into two subtypes Inhibited and Disinhibited.

The first subtype is Inhibited; "The inhibited subtype refers to children who persistently and pervasively fail to initiate and to respond to social interactions in a developmentally acceptable way" (Schwartz & Davis, 2006, p.472). When in distress a child with an inhibited pattern of attachment does not consistently see comfort from others and may also be fearful of seeking comfort. This child may also fail to respond to comfort given or resist the comfort (Boris & Zeanah et al., 2003). "This pattern of behaviors is based on a child's expectation that others cannot be depended on to respond in a warm or sensitive manner when support or comfort is needed" (Haugaard & Hazan, 2004, p.158). Haugaard and Hazan (2004) provide the following list of behaviors as possible indicators of Inhibited RAD.

> Withdrawing from other, especially after experiencing psychological or physical pain; avoiding comforting comments or gestures or dismissing them as unnecessary or unwanted; engaging in self-soothing behaviors; exhibiting "frozen watchfulness" or other

> signs of vigilance; displaying aggression toward peers; failing to ask for practical assistance or support when needed, especially among school-age children and adolescents; showing consistent obvious awkwardness or discomfort in social interactions, especially among school age children and adolescents; and masking feelings of anger or distress, especially among older children and adolescents. (p. 158).

Inhibited RAD also known as emotionally withdrawn RAD has been commonly identified in children with histories of maltreatment, and those who are being raised in institutions (Boris & Zeanah et al., 2003).

The second subtype of RAD is disinhibited also known as indiscriminate. Schwartz and Davis (2006) describe this as; "children who are indiscriminately sociable or demonstrate lack of selectivity in their attachments" (p. 472). Haugaard and Hazan (2004) report that Disinhibited RAD; "is based on a child's belief that others are not fully competent or willing to be responsive but can be coerced or convinced to proved needed comfort and affection" (p.158). Children with Disinhibited RAD tend to be; "vigilant for opportunities to obtain affection or care... often appear needy, dependent, or ingratiating" (Haugaard & Hazan, 2004, p. 158). Some indicating behaviors include:

> Exhibiting developmentally inappropriate childishness, especially around adults; being inappropriately affectionate or familiar with relative strangers; seeking comfort from person with whom no prior relationship exists; expressing distress for no apparent reason or exaggerating needs for assistance; appearing chronically anxious, even in nonthreatening situations; being the frequent victim of bullies; developing intense romantic rushes easily and often, especially among adolescents; frequently experiencing

> victimization in relationships; and being sexually promiscuous (Haugaard & Hazan, 2004, p. 158).

Connor, Brendenkamp, & Rutter (1999) found that children with RAD "demonstrate maladaptive attachment behaviors specifically with regard to how they cope with exploration, fear, and wariness" (cited in Schwartz & Davis, 2006, p. 473). Schwartz and Davis (2006) also cite; Aber, Allen, Carlson, and Cicchetti (1989) who found that; "children who are maltreated exhibit poor self-esteem, and self regulation, poor peer relations, and developmental and cognitive delays" (cited in Schwartz & Davis, 2006, p. 473). Additionally children diagnosed with RAD may display a wide variety of maladaptive behaviors including; property destruction, aggression, hoarding food, stealing, lying, bullying, cruelty to animals and people, poor impulse control, hyperactivity, low frustration tolerance, and a lack of empathy (Schwartz & Davis, 2006, p. 474).

While lists of behaviors can be helpful for a school counselor; school counselors and school personnel must use caution when working with these lists of behaviors. The list of behaviors that may be associated with RAD is extensive and sometimes not clearly defined within the diagnostic criteria. Several schools of thought about attachment disorders have published lists for use in diagnosis however caution must be used to rule out other disorders. Chaffin, et al. (2006) states that; "Several other disorders share substantial symptom overlap with RAD and, consequently, are often co-morbid with or confused with RAD....disorders such as conduct disorder, oppositional defiant disorder, and some of the anxiety disorders, including posttraumatic stress disorder" (Chaffin, et al. 2006, p. 81). Working with practitioners to rule out or confirm other diagnosis will help the counselor better work with the child in the school setting

to improve problem behaviors. Also note that developmental age and culture must be taken into consideration when determining whether behaviors are maladaptive

The behaviors associated with RAD are complex. School personnel need to understand the behavior in the context of attachment related problems. Understanding behaviors in this capacity will help to design and implement school based interventions to be effective in achieving a reduction of disruptive or destructive behaviors in the school.

Interventions and Treatments

Perhaps more controversial than determining acceptable and reliable methods for assessment and diagnosis of RAD are determining acceptable and reliable interventions and treatments for RAD.

One of the most discussed and controversial topic in the area of interventions and treatments is what is referred to as *attachment therapies*. Typically these techniques which include; holding, re-birthing, rage-reduction, re-parenting, and attachment parenting are highly controversial and lack widely accepted empirical evidence of effectiveness. While these treatments are not widely endorsed by many practitioners it is important to understand them in the context of currently available treatments and interventions. These therapies are often conducted at private institutions that claim to be founded by and/or employ experts in *attachment disorder* and *attachment therapies*.

The Evergreen Psychotherapy Center is one of the most well known centers that claim to specialize in the treatment of RAD. According to their website the Evergreen Center's effective treatment includes; creating secure attachment patterns, concentrating on several social systems of the child, holistic and integrative treatments that focus on; mind, body, emotions, behaviors, relationships, and morality, and utilizing a developmental structure that they call " Revisit,

Revise, Revitalize" (Evergreen Psychotherapy Center Attachment Treatment & Training Institute, 2004, Attachment Therapy section, para.2-4). Attachment therapy at the Evergreen Center typically occurs during an intensive 2 week program that includes therapy for 5 days a week for 3 hours each day. Therapy is done with both the child and the caregiver. Cost for the two week program is $12,500. Evergreen also conducts therapy for older adolescents through adults who have or continue to have attachment problems (Evergreen Psychotherapy Center Attachment Treatment & Training Institute, 2004, Attachment Therapy section, para.2-4).

As mentioned earlier one approach used by the Evergreen Center and other attachment therapists is holding therapy. This approach has stirred considerable controversy mostly because of its connection with other strongly invasive approaches such as rebirthing which has resulted in child deaths (O'Connor & Zeanah, 2003). Proponents of attachment therapy and holding maintain that this technique is effective in establishing new attachments between the child and the caregiver, though empirical evidence showing this is unavailable at this time. "Systematic and rigorous clinical research is needed before this treatment is proposed as a clinical tool and recommended as a form of treatment" (O'Connor, & Zeanah, 2003, p. 238).

One of the essential elements of holding therapy is close physical contact with a therapist that includes the child lying in the lap of the therapist or therapists, and engaging in touch and eye contact usually for long periods of time. (O'Connor, & Zeanah, 2003, p. 236). While conventional therapists see this as invasive, advocates for holding therapy state that holding is more intense than talking and provides the child with experiences of safety and security which is contrary to their previous experiences and relationships (O'Connor, & Zeanah, 2003, p. 236). Proponents of holding therapies assert that traditional therapies don't work with children with attachment problems and that holding therapies enhance the child's capacity to attach to others

thus repairing relationships and improving problem behaviors (O'Connor, & Zeanah, 2003, p. 236).

Other strategies for the treatment of RAD are techniques from other commonly practiced therapies such; trauma therapy, cognitive-behavioral therapy, narrative therapy, psychodrama, object relations therapy, family therapy, reality therapy and more (Cain, 2006, p. 100). Regarding treating children with RAD Cain (2006) states that;

> In order to treat an attachment disorder, you must first understand the purpose of the behaviors the child uses. Behaviors such as avoidance, aggression, and indifference are behaviors the child has learned to use as a means of protection in a potentially threatening world. Many children needed these behaviors to survive at some point and have simply continued to use them because they have become internalized, set patterns of response, even though they are no longer needed. (p. 100).

The understanding of the purpose of a child's behavior is vital and is the basis for many of the suggested intervention techniques. Each child and family system will likely need an individualized treatment plan that can focus specifically on their symptoms, past experience, temperament, available resources, and other factors (Cain, 2006, p. 100). Hauggard and Hazan (2004) state that "the goals of interventions with children who have RAD are to give the child (a) a source of emotional security, (b) opportunities for corrective social experiences, and (c)better social skills (p. 158)

Cain (2006) outlines several traditional behavior management strategies that can be used as a basic foundation from which to work from. Not all strategies are appropriate for every child and some will work better than others (p. 100). The following are a few traditional behavior management strategies that can be used to treat behaviors related to RAD and will be discussed

further: structure and routine, consistency, importance of touch, neutrality, self calming techniques, and cognitive-behavioral approaches.

Structure and routine is one of the most important elements of behavior management (Cain, 2006, p.101). Providing an environment that is predictable and similar on a day to day basis is incredibly important and provides children with a sense of security. For the younger child this will include play-time, meal-time, and bed-time happening on a consistent schedule from day to day. This technique provides children with an environment in which they can adopt patterns and organize their own thoughts and behaviors (Cain, 2006).

Another important strategy in treating behavioral issues is the use of consistency from the caregiver. A caregiver should try to act and react to the child in a consistent calm manner as much as possible. This technique helps the child learn what to expect from the caregiver in reaction to their own behavior. This can help reduce the amount of time that a child "tests" a behavior with the caregiver (Cain, 2006).

The use of touch can be very important in helping a child with RAD. Some children with RAD seem not to need or want to be touched while others will demand touch on their terms. A child with RAD may need to be gradually introduced to the use of touch. The use of touch is a technique commonly used to build attachments between the caregiver and the child. This can start with small gestures such as placing a hand on the child's shoulder or arm. As a child becomes more comfortable with touch the use of "cuddle time" can be helpful with both children who want and do not want touch. For the child who seems to not want touch a planned "cuddle time" can be offered and then rewarded when complete. Caution should be used to make sure that this is a positive time for the child (Cain, 2006).

"Neutrality means not engaging in a quarrel, argument, emotion, or battle with the child" (Cain, 2006, p.104). The child is likely to get angry and upset they do not get what the want out of a situation. The child will resort to learned behaviors to regain control. While engaged in this behavior the child is using the limbic region of the brain and is less likely to us problem solving or higher order thinking skills (Cain, 2006). A child with RAD needs help developing self-regulation skills and mastering control over their emotions. A calm, neutral caregiver will help the child with this process (Cain, 2006). This technique obviously will take a great deal of patience from caregivers.

The use of self-calming techniques can help the child learn self-regulation and learn what it feels like to be "calm" (Cain, 2006. p.110). This technique should be used during times when the child is not upset. One method would be to engage the child in active play and then challenge them to return to a calm state. As the child is calming bring awareness to the feelings of their body including muscle tension, heart rate, and breath rate (Cain, 2006). Also introduce and teach the child activities that can be used to help them calm down. Some activities might include; walking, drawing, reading, exercise, listening to music, or using mental imagery.

Cognitive-behavioral strategies provide the child with opportunities to learn new behaviors by teaching appropriate procedures and applying analytical thought to them (Cain, 2006). The child should be given opportunities to practice solutions to everyday life problems. A child with RAD may be good at coming up with a solution but might not put what they learn into practice at a later time. One technique that can help is the use of picture stories or journals. This child can write or illustrate a situation where their response was not positive or appropriate. As the child explains what happened, the caregiver can ask probing questions and encourage the child to think about the consequences of their behavior (Cain, 2006). Talking through the thought

process and feelings involved in the situation can help encourage a child to use a different thought process when responding to situations.

Cain (2006) also talks about 2 common behavior management strategies that have little success when working with children with RAD; time-outs and reward systems. Time-outs are one of the most widely used behavior modification techniques used by parents and school personnel. For a child with RAD a time-out is likely to engage them into a "fight-or-flight" response. For a child who tends to "fight", a time-out will promote a power struggle between the child and caregiver. The child will continue to "fight" until they regain control or power. For a child who tends to take "flight" a time-out allows them to escape the problem and not deal with the current situation or behavior. "Because these children are already working from a core base of shame, being put into time-out has relatively little effect on them and actually validates their negative feelings about themselves" (Cain, 2006, p.121). Reward systems are another commonly used behavior modification technique that has been shown to have little effect when used with children diagnosed with RAD. Children with RAD are operating on a core base of inner shame according to Erik Erikson's psychosocial theory (Cain, 2006, p.121). Because the child has operated in this state for so long they will engage in behaviors to keep them there. The purpose of a reward is to encourage the child to engage in good behaviors, but a child with RAD is likely to sabotage because the do not believe they are worthy of rewarded (Cain, 2006).

The treatment of RAD is a complex topic that needs a great deal of empirically based research to be conducted. School personnel need to be aware of current treatments and trends and be able to provide caregivers with information and support.

Chapter III: Discussion

This chapter discusses the research shared in the literature review. Implications for school counselors regarding behavior manifestation, assessment and diagnosis, and treatment within the schools will be discussed. Implications for future research and limitations to current research will also be discussed. The chapter concludes with a final summary of the topic.

Discussion

John Bowlby and Mary Ainsworth paved the way for the field of research regarding the affects of early attachment on a child's emotional development. The importance of early attachments between children and caregivers is unquestionable. "Repeated experiences become encoded in implicit memory as expectations and then as mental models or schemata of attachment, which serve to help the child feel an internal sense of what John Bowlby called a "secure base" in the world (Siegel, 1999. p.67). Early research regarding attachment has set the foundation for the development of the diagnosable Reactive Attachment Disorder which first appeared in the DSM-III in 1987. The most current diagnostic criteria can be found in the DSM-IV-TR released in 2000. While the diagnostic criteria exist, many argue that the DSM-IV criteria are too vague and do not encompass the problems of attachment that are being identified in populations of maltreated children. This has led some researchers to develop their own criteria and tools for diagnosing *attachment disorders.* For those who are not familiar with RAD especially school personnel who are looking for ways to help it can be very confusing and overwhelming to weed through the differences and find information useful for helping children, parents, and teachers.

The treatment of RAD also continues to be a controversial area with almost every theoretical framework providing their strategies for how to help children and families who are

affected by RAD. Some of these include; psychotherapy, behavioral therapy, cognitive behavioral therapy, and attachment therapies which may encompass techniques from several styles. Specifically the emergence of *attachment therapy* has created considerable controversy. Institutes claiming to specialize in *attachment therapy* exist and claim to hold the key to curing children with attachment disturbances. The most notable is the Evergreen Psychotherapy Center Attachment Treatment & Training Institute. Treatment at the Evergreen Center is intensive and expensive costing $12,500 for a 2 week program (Evergreen Psychotherapy Center Attachment Treatment & Training Institute, 2004, Attachment Therapy section, para.2-4). One technique that the Evergreen Center specializes in is *holding therapies*. Proponents of holding therapies claim that:

> "holding is thought to provide the child with an experience of safety and security that is contrary to previous experiences of severe abuse or neglect...experiences in holding therapy are thought to perhaps mimic the touch/holding experiences that are part of the normative attachment process between caregivers and infants" (O'Connor & Zeanah, 2003. p.236).

Other researchers in the field claim that holding therapies are not based on attachment theory and have not been proven effective in treating attachment disorder. The APA released a position statement regarding RAD and its treatments, while it does not provide specific treatment options, they stress that an "individualized treatment plan" (APA, 2002 para.4), will have the most benefit for the child. It is also clear that the APA does not endorse the use of coercive holding therapies, and re-birthing techniques because the success of these interventions is not empirically based.

School counselors are seen as a resource in their schools regarding interventions for children with behavioral problems. School counselors must be educated in traditional and contemporary treatment options. Proper education will allow them to assist in developing appropriate interventions in the school.

Implications for School Counselors

Identifying behaviors associated with RAD that manifest in a school setting. Early attachment with caregivers has a profound impact on children's social development. Specifically, "children who have a secure attachment relationship with a caring adult are more disposed to interact with other children and have greater expectations that their interactions will be positive" (Floyd, K., Hester, P., Griffin, H., Golden, J., & Canter, L. 2008, p. 47). This social development is an essential component to academic and social success in the schools and will be on the forefront of what school counselors and school personnel will be faced with while working with these children in the schools. Floyd et al., (2008) state that, "children with RAD consistently exhibit more teacher -attention seeking behaviors, over dependence upon a teacher, significantly more emotional dependency, and are more likely to engage in proximity-seeking behaviors" (p. 53).

Parker and Forrest (1993) recommend that school counselors who will work with children diagnosed with RAD gain "knowledge of the disorder" and support or conduct "research about attachment disorders" (Recommendations section, para.17) in the school setting. Specifically they need to be aware of the breadth of behaviors that will manifest in the social school environment. While commonly used lists can be helpful starting point, school counselors should conduct their own observations of the child in multiple settings. These observations will give counselors information on how the child interact differently or similarly with peers,

teachers, and parents. Observations also allow school counselors to identify the behaviors that are most inhibiting in the school setting and work to develop appropriate interventions. RAD is a complex disorder that cannot be cured in the school setting but a school counselor has a responsibility to work on specific behaviors that interfere the most with successful school functioning.

School counselors also have the task of educating other school personnel. School counselors are often seen by school personnel as the "expert" when it comes to children and problem behaviors. This comes with the responsibility of ensuring that school personnel are educated about RAD and appropriate interventions. School counselors should encourage that RAD be a topic of discussion during teacher in-services. Educating paraprofessionals such as teacher's aides, playground supervisors, bus drivers, and any other person in the school that will interact with a child in instruction or social time should is also crucial. School administrators should work together within in the district to make sure that education of teachers is consistent between schools. This is especially important because children diagnosed with RAD are more likely to have placement changes especially if they are in the foster care system.

Collaboration with parents or caregivers of children with RAD is also an important role for the school counselor. The caregivers may be able to provide important information about consistency of behaviors that are impacting both home and school life. The counselor should try to engage the parent in implementing strategies in the home that will work to improve behavior both in home and in the school. If the child is seeing an outside professional the counselor should also seek to work collaboratively with them to help provide consistency across environments. School counselors should also be collaborating with community mental health services or other family support service providers that may be working with the family.

Role of school personnel in the assessment and diagnosis of RAD. The assessment and diagnosis of RAD is a complicated issue and the role of the school counselor will vary. A clinical diagnosis of RAD will not happen within the school system and will need to be made by a clinical psychologist. Although a school counselor or school psychologist will not provide a diagnosis of RAD it is important to note that a school system can evaluate and diagnose a child with Emotional Behavioral Disorder (EBD), which allows them to qualify for services under the Individuals with Disabilities Education Improvement Act (IDEA). Since many of the behaviors are shared between RAD and EBD this diagnosis can be an important stepping stone in providing interventions to improve school functioning. A school counselor will want to work collaboratively with other school personnel such as a school psychologist and school social workers to assist in gathering information needed for evaluation.

One important variable that school counselors must not overlook is cultural and ethnic differences of children. Suzuki et al., (2006) state that, "understanding psychopathology in school-age populations requires an awareness of the complex cultural factors that influence all aspects of the interventions process beginning with diagnosis" (p.429). A school counselor must do everything possible to learn and understand cultural differences and be sensitive when working with families and the children in the school system. Cultural information that impacts diagnosis and interventions should also be communicated to other school personnel so that all groups are on the same page regarding the best approach to working with the specific child and family.

Intervention options for use is a school setting with children diagnosed with RAD. School counselors will play in integral role in developing interventions for child with RAD in the school. This may be done as a part of an IEP team or at the request of teachers. It is important to

keep in mind those children with RAD struggle with regulating emotions and forming appropriate relationships with adults and peers. This means that problem behaviors will manifest in all settings of the school environment. Comprehensive interventions will include plans for; classroom, lunch room, playground, and transportation. There is no doubt that getting all school personnel on the same page is a challenge but one that must be taken seriously to provide the child with consistency in all aspects of the school setting.

One strategy that schools can implement is Positive Behavioral Supports (PBS) throughout the school. "Positive behavioral support (PBS) is a broad term that describes a comprehensive, research-based, proactive approach to behavioral support aimed at producing comprehensive change for students with challenging behavior" (Ruef, 1998, para.1). PBS strategies aim to discover the cause of the behavior and treat that, rather than just punish for the behavior. This can be difficult with children diagnosed with RAD however if teachers have an understanding of RAD they are more likely to use strategies that are effective for reducing problem behaviors.

Hauggard and Hazan (2004) state that "the goals of interventions with children who have RAD are to give the child (a) a source of emotional security, (b) opportunities for corrective social experiences, and (c)better social skills (Hauggard and Hazan, 2004, p.158). Cain (2006) outlines several traditional behavior management strategies that can be used as a basic foundation from which to work from. The following are a few traditional behavior management strategies that can be implemented to treat behaviors related to RAD in the school setting: structure and routine, consistency, neutrality, and self calming techniques.

Structure and routine is very important for a child diagnosed with RAD. Depending on the circumstances of the child structure and routine may be something that they only get in the

school setting. Teachers should do their best to make the environment stable and predictable for the child with RAD. This can be done by outlining the schedule for the day, giving warnings before transitions, and engaging the student in the transition processes. When a change in the structure is needed the teacher should do their best to prepare the child for what is coming ahead of time.

Consistency is also very important and something that should be worked out for use with all school personnel the child interacts with. School personnel need to be on the same page on what to do if the child begins to engage in disruptive or inappropriate behavior. A plan should be in place and shared with the student. This will reinforce with the child what is expected and will help them experience consistency that they may have been missing or lacking in previous experiences.

"Neutrality means not engaging in a quarrel, argument, emotion, or battle with the child" (Cain, 2006, p.104). This is another strategy that is important to share with all school personnel. A child with RAD needs help developing self-regulation skills and mastering control over their emotions. A calm, neutral caregiver will help the child with this process (Cain, 2006, p.104). This technique obviously will take a great deal of patience from school personnel, and may be the hardest to do in a system where class sizes and demands for academic achievement are increasing.

The use of self-calming techniques can help the child learn self-regulation and learn what it feels like to be "calm" (Cain, 2006, p.110). This technique can be practiced during individual sessions with the counselor. The counselor should have an arsenal of activities or techniques that can be introduced to children to help them learn and practice ways to calm themselves. Some

activities might include; walking, drawing, reading, exercise, listening to music, or using mental imagery.

Cain (2006) also talks about 2 common behavior management strategies used in schools that have little success when working with children with RAD; time-outs and reward systems (p.121). Time-outs are one of the most widely used behavior modification techniques used by parents and school personnel. For a child with RAD a time-out is likely to engage them into a "fight-or-flight" response. The use of timeouts will likely either exacerbate the current problem and never make any gains in long term remediation of the problem behavior. Reward systems are another commonly used behavior modification technique that has been shown to have little effect when used with children diagnosed with RAD. The purpose of a reward is to encourage the child to engage in good behaviors, but a child with RAD is likely to sabotage because they do not believe they are worthy of rewarded (Cain, 2006, p.104). These two techniques are examples of how interventions must be carefully selected for children with RAD that do their best to reach motivation for the behavior rather than just simply trying to eliminate it through traditional behavior modification techniques.

One additional strategy that should not be over looked by a school counselor is their role in helping with prevention strategies. Parker and Forrest (1993) suggest that school counselors help to implement parenting skills classes and workshops to help in the prevention of RAD. One popular parent skills resource is *Parenting with Love and Logic.* Communities and schools have been using this resource for years to help parents develop skills for raising responsible children. A school counselor should develop good relationships with community agencies that can provide this training and support to families. Good relationships with social workers and social services organizations are especially important.

Limitations of Research

The purpose of this research was to provide a review of the literature surrounding RAD. It is in no way is all encompassing of the research surrounding this topic. Additionally strong empirical evidence for assessment and treatment practices are not currently available in the literature. Further research needs to be conducted and appropriate interventions and strategies for working with children with RAD need to be identified. Also current research surrounding RAD is primarily focused on young children and longitudinal research is lacking regarding how a diagnosis of RAD progresses into adolescence and adulthood.

Implications for Future Research

RAD as a diagnosable disorder is still in stages of infancy and requires a great deal of research to continue in the areas of; diagnosis, treatment, and how to best serve students with RAD in our school system.

Children starting at the age of 4 spend the majority of their time in the school setting. For many children this is the place that their foundation for social interaction and appropriate behavior is formed. Children with RAD may be attending school before they are developmentally or emotionally ready to function in the school learning environment. RAD diagnosed children struggle with regulating their emotions and behaviors when it comes to forming new relationships with teachers and peers (Schwartz & Davis, 2006. p.473). The learning that occurs outside of the classroom regarding social interactions and relationships is just as important as the content being taught in the classroom. Research needs to be done to determine how students with RAD thrive in the school social environment. Additionally research should look at how the social relationships and relationships with teachers affect the academic achievement of children with RAD. It seems possible that children with RAD who display

disruptive behaviors in the classroom may be labeled very early on as a "bad kid." Labels like these tend to follow children from one grade to the next. When teachers and counselors are not prepared or educated on RAD it is likely that they will lack the skills to help these students succeed personally and academically. Continually removing a child with RAD from the classroom and passing them off from one specialist to the next will only exacerbate the problems of the child in the classroom.

Perhaps the most important area of research that needs to be conducted is that of appropriate interventions that can be used in the school. With much of the treatment for RAD happening in a clinical setting research is lacking on best practices to be used with these children in the school setting. Teachers and counselors will resort to techniques and interventions that they have used with other children who display disruptive behaviors. Some of these may have some effect however most will not reach to what the core of the problem is for children with RAD, and that is their inability to form healthy relationships and an expectation that adults are not to be trusted.

Further longitudinal research should be conducted to investigate the effects of a RAD diagnosis on adolescents and adults. It would be particularly helpful to investigate how individuals with RAD approach relationships with friends, family, and significant others later in life. Research should also look at what kind of parents people who have been diagnosed with RAD turn out to be in the future.

Summary

The study of attachment between caregivers and infants by Bowlby, Ainsworth, and other researchers has laid the foundation for the creation of Reactive Attachment Disorder as a medically diagnosable disorder. While this diagnosis exists there clearly lacks consistency

among current researchers as to the causes, diagnosis, and treatment of this disorder. The study of RAD is in its infancy and requires a great deal of research to be conducted in the areas of assessment/diagnosis, treatment, implications for students in the school system, and long-term course of the disorder into adulthood.

School counselors will be challenged to be the "expert" in the school systems. This will include educating school personnel and parents on the causes, symptoms, diagnosis, and treatment of RAD as well as collaborating with community agencies and social services to provide preventative interventions in the communities with families. This task while daunting at times is a responsibility of all counselors in order to provide the most effective educational environments for all students.

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