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Reactive attachment disorder : diagnosis, assessment, and treatment

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Reactive attachment disorder : diagnosis, assessment, and treatment

Abstract

In recent years, there has been an increasing trend toward the use of Reactive Attachment Disorder (RAD) as a diagnosis to describe myriad problem behaviors and disturbed interactions between infants, young children and their caregivers. There is considerable disagreement about what RAD actually entails and, in particular, what types of assessments and treatment interventions to use with affected children and families (Hanson & Spratt, 2000). This paper is intended to clarify what the current research states about Reactive Attachment Disorder. It includes the definitions and diagnosis, importance of attachment, biological components, risk factors later in life, assessment, and treatment available for families who are dealing with this overwhelming issue.

REACTIVE ATTACHMENT DISORDER:
DIAGNOSIS, ASSESSMENT AND TREATMENT

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Kimberly A. Rees

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Abstract

In recent years, there has been an increasing trend toward the use of Reactive Attachment Disorder (RAD) as a diagnosis to describe myriad problem behaviors and disturbed interactions between infants, young children and their caregivers. There is considerable disagreement about what RAD actually entails and, in particular, what types of assessments and treatment interventions to use with affected children and families (Hanson & Spratt, 2000). This paper is intended to clarify what the current research states about Reactive Attachment Disorder. It includes the definitions and diagnosis, importance of attachment, biological components, risk factors later in life, assessment, and treatment available for families who are dealing with this overwhelming issue.

Reactive Attachment Disorder:

Diagnosis, Assessment and Treatment

Reactive Attachment Disorder (RAD) is a very real mental illness. A child with RAD is reacting to some type of trauma, be it neglect, abuse or some more subtle events. Due to these events, the child is unable to attach to a primary caregiver and go through the normal development that children must go through in order to function in relationships (Geoghegan, 2002)

Children with Reactive Attachment Disorder are flooding our child welfare system with an overwhelming array of problems (emotional, behavioral, social, cognitive, developmental, physical, and moral) and growing up to perpetuate the cycle with their own children. Some social service and mental health professionals believe that attachment disorder is rare, however the evidence indicates otherwise. Researchers have shown that up to 80% of high risk families (poverty, substance abuse, abuse and neglect, domestic violence, history of maltreatment in parents' childhood, depression, and other psychological disorders in parents) create disorganized/ disoriented attachment patterns in their children (Levy & Orlans, 1998). Since there are 1 million substantiated case of serious abuse and neglect in the United States each year, the statistics indicate that there are 800,000 children with severe attachment disorder coming to the attention of the child welfare system each year (Lyons-Ruth, 1996).

In recent years, there has been an increasing trend toward the use of Reactive Attachment Disorder as a diagnosis to describe myriad problem behaviors and disturbed interactions between infants, young children and their caregivers. There is considerable disagreement about what RAD actually entails and, in particular, what types of assessments and treatment interventions to use with effected children and families (Hanson & Spratt, 2000). This paper is intended to clarify what the current research states about Reactive Attachment Disorder. It includes the definitions and diagnosis, importance of attachment, biological components, risk factors later in life, assessment, and treatment available for families who are dealing with this overwhelming issue.

Definitions and Diagnosis

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), defines Reactive Attachment Disorder of Infancy or Early Childhood by the following criteria (American Psychiatric Association, 2000):

- A. Markedly disturbed and developmentally inappropriate social relatedness beginning before age 5 as evidenced by (1) persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (referred to as inhibited type) or (2) diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate

selective attachments (e.g. excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures, otherwise known as disinhibited type).

- B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in Mental Retardation) and does not meet the criteria for a Pervasive Developmental Disorder.
- C. It also includes that Pathogenic care as evidenced by at 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/or (3) repeated changes of primary caregiver that prevent formation of stable attachments (e.g. frequent changes in foster care).
- D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

(p. 130)

Current researchers have criticized the diagnostic criteria for Reactive Attachment Disorder in the DSM-IV-TR, stating that it fails to address the full spectrum of the disorder, allowing diagnosis only in the extreme cases of attachment disturbances and that it tends to de-emphasize the child's behaviors with the attachment figures by focusing on the "reactive" nature of the disorder

(Zeanah & DeAngelis, as cited in Wilson, 2001). Zeanah (1996) proposed a system that identifies three major types of attachment disturbances, which are the following: (1) nonattached, (2) disordered, and (3) disrupted. Children classified as nonattached are those over the cognitive age of 10 months old who have shown no preferred attachment to anyone. Two subtypes of this group would coincide with the subtypes of the DSM-IV-TR: nonattachment with indiscriminate sociability (disinhibited) and nonattachment with emotional withdrawal (inhibited). Disordered attachments would characterize those children who do not use the caregiver as a secure base of exploration. Three subtypes of disordered attachment are described: (a) a child who is excessively clingy and inhibited in exploration (disordered attachment with inhibition), (b) a child who fails to check back with the caregiver in times of danger (disordered attachment with self-endangerment), and (c) a child who tends to worry excessively about the emotional well-being of the caregiver (disordered attachment with role-reversal). Disrupted attachment describes the grief response upon the loss of a primary caregiver. Because of the importance of the attachment figure during the first 3 years of life, Zeanah suggested that the loss of the attachment figure at this time would be qualitatively different than at other developmental stages, predisposing a child to problems in attachment.

It is important to note that the RAD diagnosis refers to more than attachments with the child's primary attachment/caregiver relationship alone; it

more broadly refers to disturbances in a child's social abilities and relationships across individuals and contexts (Richters & Volkmar, 1996). Furthermore, the terms bonding and attachment are not synonymous. Bonding refers to the feeling that the caregiver (usually the mother) has toward her infant or child, whereas attachment refers to the feelings the child has toward the caregiver. In RAD, both bonding and attachment are impaired.

Importance of Attachment

As defined by Bowlby and Ainsworth (as cited in Levy & Orlans, 1999), pioneers in the study of parent-infant relationships, attachment is an enduring affective bond characterized by a tendency to seek and maintain proximity to a specific person, particularly when under stress. Thus, attachment is the deep and long-lasting emotional connection established between a child and caregiver in the first several years of life. In normal developmental attachment, the first year of life is depicted by a child getting his or her internal needs met sufficiently by his or her primary caregiver (typically the mother). A trust cycle begins to develop as the child has a need (i.e. hunger), displays a rage reaction (i.e. crying) and his or her need is met (i.e. mother feeding), therefore providing gratification or relief for the child. This cycle is repeated hundreds of times a week and thousands of times in the first year (Becker-Weidman, notes on attachment, para. 9). Psychosocial theorist, Erik Erikson defined this developmental stage of infancy as the *Trust versus mistrust* period, in which significant others provide for

basic physical and emotional needs therefore developing a sense of trust between infant and caregiver (Corey, 1996).

As the child grows into the second year of life, the same type of trust cycle is continued. The child expresses a need or want, his or her caregiver sets appropriate limits, the child responds by either accepting, testing or defying limits, and the caregiver responds appropriately by displaying a balance of structure and independence. Erikson defined this developmental stage as *Autonomy versus shame and doubt*, a basic struggle between developing a sense of self-reliance and a sense of self-doubt (Corey, 1996). Levy and Orlans (1998) concluded that secure attachment relationships serve many important functions for children developmentally such as:

- 1) providing safety and protection for the vulnerable young via closeness to a reliable and consistent caregiver;
- 2) teaching basic trust and reciprocity which serves as a template for all future relationships;
- 3) facilitating healthy cognitive and social development via safe and secure exploration of the environment;
- 4) promoting self-control, the ability to regulate and manage impulses and emotions;
- 5) leading to the formation of healthy identity, self-worth and autonomy;

- 6) establishing prosocial morality, which includes empathy, compassion and conscious;
- 7) generating positive core beliefs (internal working models) about self, others, and life in general; and
- 8) protecting children against future stress and trauma by increasing resilience. (pp. 1-2)

Secure attachment can only be established in the context of a relationship that includes nurturing touch, safe holding, eye contact, smile, positive affect, and need fulfillment. Securely attached children learn to trust caregivers and authority and believe that their own needs are valid (Levy & Orlans, 1998).

The developmental sequence that characterizes a secure attachment contrasts significantly with that of a child who experiences chronic neglect, abuse, and placement with multiple caregivers. The above mentioned cycle of trust in the first year of life is thwarted because as the child displays a need, the caregiver(s) does not meet that need in a consistent, appropriate way and as a result the child develops a rage reaction, learning therefore that others cannot be trusted. Often the maltreated child does not discover that he or she is special, does not learn the joy and interest that is elicited from experiences of shared affect with his or her caregiver, and does not feel affirmed, identified, or important. Instead, he or she increasingly feels isolation and sadness and may eventually feel despair. Because his or her basic needs for food, warmth and physical comfort

are most likely not consistently met, his or her interests increasingly turn to meeting these basic needs (Hughes, 1998).

Children with attachment disorder mistrust authority and develop negative self-perceptions (e.g. I am bad, defective, unlovable). Bowlby described, (as cited in Hayes, 1997), that children with attachment disorder block internal and external signals that prompt them to give and accept love. They will use defense reactions that prevent attachment as protection against any forthcoming perceived emotional trauma. The following scenario depicts a typical example of what life is like for a child with Reactive Attachment Disorder. A child who generally does not feel remorse for his actions, has limited empathy for others, and fabricates lies so absurd no one would believe him. A child who has never felt or understood the connection he could have with a loving caregiver. A child so wounded from a past he may not even consciously remember, that he inadvertently creates an emotional barrier so thick to protect himself, which eventually ends up isolating him from others. These, along with other behavioral responses, reflect what is happening internally inside the mind and body of a child with Reactive Attachment Disorder and remind professionals of the importance of understanding and appropriately treating these children.

Scenario

Imagine Bobby, a charming 6 year old boy, at recess “innocently” kicking at the heels of a younger girl he does not even know, then quickly being

reprimanded by the adult on duty, and sent back inside to his classroom. While restlessly sitting with his head down at his desk he sees an action figure hanging out of his classmate's jacket. Bobby's teacher Mrs. White, unsuspectingly concentrating on getting her papers graded before the recess bell rings, does not notice when Bobby quietly sneaks over to the coat rack, taking the action figure and shoving it into the sleeve of his sweatshirt. Shortly thereafter, the recess bell rings and a swarm of students race to their desks as Mrs. White finishes organizing the graded papers. As she turns to address the class, she notices an unusual lump on the side of Bobby's arm. Mrs. White walks over to Bobby and asks him to remove his arm from his sleeve. Bobby is reluctant at first responding, "Why? My arm is just fine!" But Mrs. White persists, knowing that Bobby has a history of "sticky fingers," and Bobby removes his arm as the action figure plummets to the ground. His teacher asks where he got the toy and whose toy it is. Bobby looks her straight in the eye and states it is his and he only hid it because he thought he would get into trouble for having it during class. Just then Bobby's classmate Aaron yells, "Hey, that's mine!" Mrs. White gives Bobby "the look" that he is in big trouble yet Bobby shows no remorse as he gives the toy back to Aaron. In the principle's office, Bobby exclaims that Aaron must have somehow put the toy into his sleeve at recess to try and get him into trouble even though he realizes that the possibilities of this actually happening are none. Before the principle can refute Bobby's convoluted story, the principle's wife

who appears to be in crisis interrupts the two. Bobby turns to the wife and begins to ask her if he can go home with her all the while smiling and pouring on the charm. The wife gives her husband a puzzled look and rambles something about a leaky roof. The principle, realizing the importance of both situations, states that he will be in contact with Bobby's parents to address this issue later and now Bobby needs to go back to class. Bobby smirks and begins to think of the story he will try to convince his adoptive parents when he goes home that afternoon. Bobby's story plays out what a typical situation might look like in the life of a child with Reactive Attachment Disorder. It is important to not only understand the behaviors of these children, but also to examine some of the biological components, which are key for effective treatment.

Biological Components

To further understand attachment, it is important to consider the function and chemistry of the human brain. The brain is composed of three parts, each evolving at a different time in the growth period of an infant and for a different purpose. The brain stem is the first to evolve and regulates the basic life functions (i.e. digestion, breathing, reproduction, and metabolism) necessary for survival. The next part of the brain to develop is the limbic system, which provides the ability to experience emotions, refines the capacity for learning and memory, and upholds the immune system (self-healing). The third and final part of the brain to develop is the neocortex, which controls thinking, reasoning, creativity, and

symbolic language. It enables humans to observe our own emotions and have choices about our response (Allred & Keck, 1996). The first two parts in development control a person's social behavior, which govern maternal instinct, attachment behavior, self-preservation, and stress-related responses. When threat or danger is sensed, a part of the limbic system triggers the release of stress hormones (i.e. cortisol). Children with attachment disorder have often had repeated releases of hormones and their trauma, fear, anxiety, and painful emotions are lodged in the primitive (1st & 2nd) parts of the brain. Allen N. Schore and Daniel Siegel, infant researchers at UCLA, (as cited in Lott, 1998) revealed a correlation between the dialogue of caregiver-infant attunement with simultaneous neurobiological states. During the development of the 2nd limbic part of the brain, the infant is communicating with his or her caregiver directly "right brain to right brain." Schore contended that abuse, neglect and chronic states of misattunement lead to an impaired ability to regulate emotion in response to stress. When the caregiver is in attunement with the child, there is a regulating affect (i.e. mother coming to comfort the child) thus reducing the levels of cortisol and related stress hormones. When there is no interactive repair, infants may remain in chronically negative states, which result in altered limbic system states. In a study of adolescents, Teicher, Ito, and Glod (1997) found abnormal EEG readings in the frontotemporal or anterior regions in 42.9% of those with a history of psychological abuse, 54.4% of those with physical/sexual abuse, and 71.9% of

the subsample with serious physical/sexual abuse, as compared to 26.9% of adolescents with no abuse. These findings imply a strong correlation between abusive relationships and the risk factors for persons later in life.

Risk Factors Later in Life

Levy and Orlans (1998) stated that children who begin their lives with compromised and disrupted attachment (associated with prenatal drug and alcohol exposure, neglect of physical and emotional needs, abuse, violence, and/or multiple caregivers) are at risk for serious problems as development unfolds. These problems can include the following factors: (a) low self-esteem; (b) needy, clingy, or pseudoindependent characteristics; (c) decompensate when faced with stress and adversity; (d) lack of self-control; (e) unable to develop and maintain friendships; (f) alienated from and oppositional with parents, caregivers, and other authority figures; (g) antisocial attitudes and behavior; (h) aggression and violence; (i) incapable of genuine trust, intimacy, and affection; (j) negative, hopeless, and pessimistic view of self, family and society; (k) lack empathy, compassion, and remorse; (l) exhibit behavioral and academic problems at school; and (m) perpetuate the cycle of maltreatment and attachment disorder in their own children when they reach adulthood. Widon (1998) recently published an article in the *American Journal of Orthopsychiatry* that studied the relationship between maltreatment, multiple placements, and criminal behavior (para. 1,4). Her findings give evidence that multiple placements in the foster care system due to

behavior problems were a strong correlate to later criminal behavior. Children with attachment disorder are at a higher risk for multiple placements due to the severity of their behavior. Raine (1993) also denoted that teenage boys who have experienced attachment difficulties early in life, are three times more likely to commit violent crimes. The disruption of attachment during the crucial first years of life can lead to what has been called “affectionless psychopathy”; the inability to form meaningful emotional relationships, coupled with chronic anger, poor impulse control and a lack of remorse. These disturbing psychosocial qualities have contributed to a more violent and “heartless” character to the crimes being committed by today’s youth (Levy & Orlans, 1998). Realizing the dangers that children with attachment disorder can have on families, as well as society in totality, the importance of being able to accurately diagnose and effectively treat these relational issues become crucial.

Assessment

Even though the DSM-IV-TR clearly states the diagnostic criteria involved in diagnosing a child with Reactive Attachment Disorder, researchers are finding that there are differences between Reactive Attachment Disorder and Attachment Disorder. Dr. Elizabeth Randolph, researcher at the Attachment Center in Evergreen, Colorado stated the following:

Because the behavior of children with attachment disorder often appears similar to (and is often misdiagnosed as) conduct disorder, oppositional-

defiant disorder, and/or attention deficit hyperactivity disorder, it is important to be able to distinguish those children whose behavior problems indicate the presence of attachment disorder from those who have other disorders (Randolph, para.1)

Prior to 1997, the primary tool used to assess and diagnose attachment disorder was the Symptom Checklist, a tool developed at Evergreen Consultants in Colorado. The Checklist was developed to describe the symptoms that therapists had observed when treating children with attachment disorder (Randolph, para.1). However, no research had been completed to determine the validity or reliability of the Checklist at that time. Then in 1997, Dr. Randolph developed the Randolph Attachment Disorder Questionnaire (RADQ) assessment that is currently being used by therapists and school personnel to assist in identifying and diagnosing attachment disorder in children between the ages of 5 and 18 years old. Research has been conducted to affirm the reliability and validity of the RADQ in assessment and diagnosis of attachment disorder. The advantages of using this assessment tool are that it can differentiate between other diagnoses, estimate the severity of the attachment disorder, and may indicate whether the child experiences an anxious, avoidant or ambivalent type of attachment disorder (Randolph, para.3). Dr. Randolph has hypothesized that attachment disorder is a distinct and separate diagnosis than Reactive Attachment Disorder (which describes a lesser degree of psychopathology) and that children

with attachment disorder must meet the diagnostic criteria for both Reactive Attachment Disorder and either Oppositional Defiant Disorder or Conduct Disorder (Randolph, 1997, para.3). Therefore, the RADQ, would not be a permissible tool to use in assessment of only Reactive Attachment Disorder itself.

In addition to specific tools such as the Symptom Checklist and RADQ, it is important to understand that effective assessment must be comprehensive-- based on as complete an understanding of the child and family as is possible (Levy & Orlans, 1995). Assessment and diagnosis of attachment disorder rest on three major factors: early history, historical and current symptoms, and direct observation of relationship patterns. Early history and symptomology provide the initial diagnosis prior to treatment, however, once treatment begins, direct observation of the child's attitudes and behaviors with attachment figures is primary. Direct observation of relationship patterns, as well as parental descriptions of interactions in the home, enable the clinician to focus on specific signs of attachment disorder. Some clinicians, such as Dr. Arthur Becker-Weidman, have described the importance of multi-faceted assessments which include the following: (a) a detailed review of the child's first three years of life and prenatal history; (b) all pertinent documents including protective service reports, court summaries, and prior evaluations; (c) a complete review with the parents of the child's behavior and symptoms including the child's responses to need, pain, and affection as well as the child's need to control and be in control;

(d) an evaluative meeting with the therapist which might include projective tests such as House-Tree-Person or the Child Apperception Test; (e) the parents completion of the Randolph Attachment Disorder Questionnaire; and (f) a meeting with the parents to review the assessment and treatment plan (Becker-Weidman, Diagnosis of reactive attachment disorder, para 1). Other clinicians would go to the length of including school history, core beliefs about self, caregivers, and life in general, and inner child metaphors or drawings to assist in assessment (Levy & Orlans, 1998). Regardless of how detailed the initial assessment is, it is important to remember that assessment is part of the treatment process and therefore occurs at regular intervals throughout the course of treatment.

Treatment

Most traditional therapy involves talk therapy, and is based upon the development of a therapeutic relationship between therapist and client. This relationship requires mutual trust, respect, reciprocity, emotional honesty and the ability to formulate thoughts and feelings into words. Children with attachment disorder are unable to make use of such methods because (a) they do not trust; (b) they are not emotionally honest, and in fact are frequently not able to identify their feelings or what is behind those feelings; (c) they do not respect anyone, including themselves; (d) they are not capable of reciprocal give and take relationships; (e) their backgrounds of abuse, neglect, unresolved trauma or pain,

loss and abandonment frequently occurred during the first year or two of life, prior to conscious memory of events; (f) they do not know why they feel and act as they do and (g) they are operating in the only way they know how to survive (Attachment center, para 8). In addition to these truths, the above-mentioned research by Schore and Siegel (as cited in Lott, 1998), begins to bridge the gap into reasons why conventional therapeutic approaches are typically not effective. Traditional approaches are directed towards the neocortex (3rd part in development of the brain) and this intellectual approach does not provide access to attachment disorder children in ways that are necessary for healing and positive change.

Traditional psychotherapeutic approaches are too often ineffective with severely attachment-disordered children because compromised attachment in the early years results in a need to control, fear of closeness, and a lack of reciprocity. The therapeutic challenge is to instill the basics--trust, empathy, cooperation, and conscious--qualities essential for successful living in a family and community.

Goals of Treatment

Therefore, the goals of treatment need to include aspects such as: (a) being able to validate the child's feelings; (b) identifying, appropriately expressing and regulating feelings; (c) resolving early trauma; (d) working through grief and loss issues; (e) cognitively restructuring faulty thinking patterns; (f) learning to see the world and the child's place in it in more realistic terms; (g) helping the child to

develop a positive sense of identity; (h) helping the child to reshape his or her behavior to more appropriate and socially acceptable levels; (i) helping the child learn how to relate to others in a respectful, responsible, and reciprocal way; (j) helping the child to develop thoughtful decision making skills; (k) helping the child to experience and accept loving, nurturing care; and (l) increasing the child's self-control abilities (Attachment center, para 18). Levy and Orlans (1998) described specific ways in which therapists can incorporate these goals into the treatment process by four components: (1) creating secure attachment patterns; (2) utilizing systemic interventions; (3) incorporating holistic and integrative interventions; and (4) revisiting, revising, and revitalizing.

Treatment Process

1. Creating secure attachment patterns: The primary therapeutic goal is to facilitate secure attachment in the parent-child relationship. To achieve this goal it is necessary to recreate the elements of secure attachment, which were unavailable in the child's early developmental stages. In the context of the Holding Nurturing Process (HNP), or otherwise known as therapeutic holding, children are provided with structure, attunement, empathy, positive affect, support, and reciprocity. The HNP is a therapeutic relationship and milieu which promotes secure attachment via social releasers, safe containment, corrective touch, access to "old brain" functions which control attachment behavior, and the development of a secure base in which positive developmental changes occur

(Levy & Orlans, 1998). The HNP is not a method or technique—it is a relationship context in which other methods are employed (e.g. cognitive rescripting, teaching prosocial coping skills). Henningsen (1996) described the impact of therapeutic holding on a child and family:

Therapeutic holding work allows the child to access deep, genuine, and intense emotions needed to work through the feelings, not simply get over them. A corrective emotional experience is orchestrated allowing the child to express these feelings, recognize and recall them and identify the events and the people involved. In essence, the child going through this experience with their parents allows for resolution of old pathological emotions while simultaneously creating powerful new bonds. (p. 3)

It should be clarified that the term “holding therapy or therapeutic holding” describes a process of physical containment by utilizing nurturing holds to facilitate connection between therapist and child, and to provide a safe environment for exploration of feelings and confrontation of behavior. All holding therapy occurs by skilled and competent therapists and at no time is the child put in any position for possible physical jeopardy (Attachment Center at Evergreen, Fall 1995, para. 7 & 9). There has been limited research to support the controversial intervention of holding therapy, however, a few studies did show

significant improvement in behavior of children who had had holding therapy versus the simultaneous control groups (Randolph & Myeroff; Lester, as cited in Wilson, 2001).

2. Utilizing systemic interventions: Attachment develops and is maintained in the context of overlapping relationship systems, including parent-child, marital, family, extended kin, and community. For example, it is common for attachment-disordered children to “triangulate” parents and other caregivers, playing one against the other. Effective treatment must address the various social systems in the life of the child and family. Children with attachment disorder need help in connecting to families, whether it be the biological families in which significant changes have occurred or foster/adoptive families in which healing is needed because the relationships were non-connecting (James, 1994). Families may benefit from sorting out “who we are” as a group. Structured family work using activities such as play, detective work, and dramatic reenactment of family stories can help develop an awareness of family history, values, and culture-- a family identity.

3. Incorporating holistic and integrative interventions: Treatment focuses on mind, body, behaviors, emotions, relationships, and values. Therapeutic interventions and strategies are varied-- experiential, psychoeducational, cognitive, skill-based (Levy & Orlans, 1998). Examples of these types of interventions may include utilizing bodywork, art, or other types of play to teach

the names of emotions and how they are experienced in the body or used to teach communication or social skills (James, 1994). This approach is based on the concept that many factors interact to create both health and dysfunction.

4. Revisiting, revising, and revitalizing: Treatment is developmental, requiring the successful completion of each stage building upon the next. The first stage of the healing process involves revisiting prior significant attachment and trauma experiences (e.g. separation, abandonment, abuse, neglect, multiple placements, and violence in the home). Through the process of revisiting, the therapist gains valuable diagnostic information and understanding of the child's internal working model, emotional responses, and interpersonal patterns (Levy & Orlans, 1998). The second stage in the therapeutic process is revisioning. The focus now becomes both developing secure attachment patterns that were never previously established, and revising disturbed attachment patterns that were created early in life. Several factors play an important role in this stage including recognizing this as an ongoing process, working on cognitive restructuring (i.e. challenging the child's negative working model combined with positive emotional change), and the therapist functioning as a "secure base" for the child by providing safety, consistency, empathy, guidance, and support. Last, revitalization includes celebrating achievements, cementing positive changes, creating plans, and enhancing hope for the future. This stage may include family renewal, moral and spiritual evolution, and forgiveness aspects.

Conclusion

Researchers are still discussing and attempting to understand all that envelops the diagnosis, assessment, and treatment of Reactive Attachment Disorder. Even the diagnosis itself, as recorded in the DSM-IV-TR, is currently being critiqued and different models are being explored that more accurately depict the nature and distinctions that encompass this fascinating disorder. Zeanah (1996) promoted that by incorporating developmental research, the diagnostic criteria in the DSM-IV-TR, could be expanded to include a larger array of children who are in stable, yet dysfunctional attachment relationships. As researchers continue to identify common factors in children already diagnosed with RAD, the challenge will be to validate diagnostic criteria and conduct additional research to determine more specific categories. Nonetheless, Reactive Attachment Disorder is an important issue that needs additional attention so that children may learn how to love, trust, and grow to become adults who can engage in healthy attachments with their own children.

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