

Clinical Guidelines Series 2009
Reactive Attachment Disorder (RAD):
Appropriate and Inappropriate Application of the Reactive Attachment Disorder
Diagnosis on an Age Continuum from Birth through Age 18

Prepared by the
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Overview of Reactive Attachment Disorder (RAD)

Reactive Attachment Disorder was first introduced into the Diagnostic and Statistical Manual (DSM-III) in 1980. It was revised in the DSM III-Revised and has remained substantially the same since (American Academy of Child and Adolescent Psychiatry; AACAP, 2005). This makes Reactive Attachment Disorder a relatively new diagnosis; and, despite over 50 years of research on the importance of human relationships in child development (e.g., Bowlby, 1944; Spitz, 1950), the diagnosis was created and refined without empirical evidence for the diagnostic criteria. While the diagnosis appears to have face validity given the number of children with behavioral and emotional difficulties that accompany a history of neglectful and/or abusive early care, there remains substantial controversy about the diagnosis and treatment of Reactive Attachment Disorder.

As early as 1945 (Goldfarb, 1945; Levy, 1947), studies were establishing that children raised in institutions, with both maternal and material deprivation, demonstrated problems with growth, cognitive development, language development, feeding and sleeping, aggression, hyperactivity, and excessive attention seeking and sociability with strangers compared to children in foster care. More recent studies of children in Romanian orphanages (Rutter, Kreppner, & O'Connor, 2001; Zeanah, 2000) note that while these issues are present, they are not present for all children to the same degree. Zeanah and Smyke (In press) note that when they leave the orphanages, many of these children "seem to have recovered fully" from the institutional experience. It is very interesting to note that in Tizard's landmark studies in the 1970s with children institutionalized in the first four years of life, of those who spent the entire first three years in an institution with approximately 50 different caregivers per week, a full third managed to develop a selective attachment relationship. This speaks to the resiliency of children and to the likely rarity of Reactive Attachment Disorder in relatively less deprived conditions.

The emphasis on the attachment relationship as a critical factor in child mental health has its roots in the theory about parent and child relationships initially described by John Bowlby (1969, 1982). Bowlby described attachment as a set of behaviors exhibited by young children that involve seeking proximity to and/or direct contact with a primary caregiver or small set of caregivers when scared or hurt. Emde (1989) described that these behaviors have specific functions for both the child and the primary caregiver. Namely the parent provides and the child receives, comfort, warmth, empathy and nurturance, emotional regulation, and physical and psychological protection. For the child, then, these experiences form the basis for developing an understanding of human relationships as trustworthy and dependable. The process of understanding relationships as *safe* or *not safe* and as *secure* or *not secure* continues throughout the life cycle; but it is seen as having particular importance in the early infancy and childhood years, as the primary caregiver (in ideal circumstances) consistently, sensitively, and accurately responds to the child's signals of pleasure, distress, and need. In terms of psychopathology, it is suggested that abusive, neglectful, or otherwise compromised caregiving can result in the child developing a view of

relationships as untrustworthy, undependable, and unsafe; and the child behaves accordingly.

Terminology

Diagnostic Criteria

In the Diagnostic and Statistical Manual IV-TR (DSM IV-TR, 2000) Reactive Attachment Disorder is defined as a condition of “markedly disturbed and developmentally inappropriate social relatedness in most contexts; symptoms begin before age 5 years and are associated with grossly pathological care” (p. 130). The DSM-IV-TR describes two subtypes of the disorder; one in which the child shows a pattern of “excessively inhibited, hyper-vigilant, or highly ambivalent and contradictory responses” (p. 130) and the other in which the child exhibits “indiscriminate sociability with marked inability to exhibit appropriate selective attachments” (p.130). The DSM-IV-TR also notes that the diagnosis can not be given in the presence of a pervasive developmental disorder since that disorder would also cause social abnormalities.

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised Edition (DC 0-3R; Zero to Three, 2005) was designed specifically for children three years old and younger as a response to practitioners who noted that the DSM IV-TR often did not address the symptom presentations specific to young children. Its description of Deprivation/Maltreatment Disorder of Infancy, (RAD), is notably similar to that in the DSM IV-TR, but is expanded and is therefore more useful. It must be noted, however, that the utility of this is limited to the young children for whom the expanded criteria was written. The DC 0-3 describes Deprivation/Maltreatment Disorder of Infancy as a disorder that manifests in *some* children who have been severely neglected or have a documented history of physical or psychological maltreatment, or who have not had the opportunity to form selective attachments as a result of frequent caregiver changes or unavailability (i.e., institutionalization). The DC 0-3R indicates that children with this disorder have “markedly disturbed and developmentally inappropriate attachment behaviors in which (the) child rarely or minimally turns preferentially to a discriminated attachment figure for comfort, support, protection, and nurturance” (p. 18). It should be noted, however, that there are apparently no documented cases of RAD resulting from physical abuse in the literature. In fact, research indicates that physical maltreatment is much more likely to result in a disorganized attachment style (Carlson et al., 1989; Vorria et al., 2003; Zeanah, Smyke, Koga, and Carlson, 2005), which is a risk factor for later psychopathology, but is not itself a psychiatric diagnosis.

The DC 0-3R describes three patterns of Deprivation/Maltreatment and then describes the need to rule out Pervasive Developmental Disorder, which may better explain the symptoms observed. The first pattern described is the “emotionally withdrawn or inhibited pattern.” It requires evidence of three of the following: “A) rarely or minimally seeking comfort in distress, B) responding minimally to comfort offered to alleviate distress, C) limited positive affect and excessive levels of irritability, sadness or fear,

and D) reduced or absent social and emotional reciprocity (e.g., reduced affect sharing, social referencing, turn-taking, and eye contact). The second pattern described is the “indiscriminate or disinhibited pattern.” This pattern describes children who exhibit attachment behaviors, but do not direct them selectively. It requires evidence of two of the following: “A) overly familiar behavior and reduced or absent reticence around unfamiliar adults, B) failure, even in unfamiliar settings, to check back with adult caregivers after venturing away, and C) willingness to go off with an unfamiliar adult with minimal or no hesitation.” The third pattern is a mixed pattern and requires two or more criteria from both the first and second patterns.

While these criteria are more elaborate than those in the DSM-IV-TR, one must remember that they apply only to infants and young children. They do not apply to school age children or adolescents.

Zeanah and Smyke (In press) note that the inhibited pattern of RAD is rarely seen in institutionalized children once they have been adopted. Conversely, they note that the tendency to wander off with strangers often remains for children long after they have been adopted and have even developed a secure relationship with their primary caregivers. Older children with a history of pathogenic care may be diagnosed with RAD because they are “charming to strangers” but then extremely defiant and disrespectful to their primary caregivers. This dichotomy is viewed by some therapists as indicative of the “indiscriminate sociability” of RAD. By contrast, Zeanah and Smyke (In press) point out, that children who have experienced severe early deprivation are typically not perceived by strangers as “charming.” Rather, they are experienced as physically intrusive.

As these children age, research indicates they exhibit a reluctance to request assistance from others. As noted above, they may continue to lack stranger wariness. They are often impulsive and experience difficulty with transitions. They have trouble delaying gratification and have poor problem solving skills. These same issues are also present for some children with organic brain dysfunction or pervasive developmental disorder. Teasing out the appropriate diagnoses, particularly in older children, requires thorough assessment across a number of domains (Zeanah and Smyke, in press).

Comments about Attachment and its Disorders

As emphasized in these diagnostic criteria (above), the diagnosis of Reactive Attachment Disorder refers to pervasive disturbances in the child’s social abilities and relationships across individuals and contexts, rather than just with the child’s relationship with his or her primary attachment figure (Hanson & Spratt, 2000; Richters & Volkmar, 1994;) Hanson and Spratt (2000) note that the parents’ responses to the child’s attempts to establish security within the relationships can be a contributing factor to the diagnosis. Zeanah and colleagues (Zeanah, Mammen, & Lieberman, 1993) suggest that disturbances of attachment move from being risk factors for later psychopathology to clinical disorders in their own right “when the emotions and behaviors displayed in attachment relationships are so disturbed as to indicate or

substantially to increase the risk of persistent distress or disability in the infant” (p. 332-349).

Zeanah and group also point out that the diagnosis was initially intended for young children and that expanding it to older children leads to less diagnostic precision. Therefore, clinicians may inaccurately diagnose RAD when children present as Conduct Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, or even with Pervasive Developmental Disorder. They warn that, when misdiagnosis happens, treatment deviates from what has been shown to be effective with those diagnoses to questionable treatments that lack a scientific basis and which may actually be harmful to children (see section on Controversies.)

When one considers the psychological tasks of older children, beginning as early as what Erickson (Erikson, 1968) described as “autonomy versus shame and doubt”, but more importantly when children reach school age and manage the challenges of “industry versus inferiority” and “group identity versus alienation,” one can see how difficult it is to assess attachment behaviors in older children. Older children’s tasks of differentiating themselves from their parents and their development of more abstract thoughts makes interpreting the underlying root of their behaviors more complicated. School age children do not exhibit the same attachment behaviors as younger children, nor do they perceive threats in the same way younger children do. Older children are more capable of managing their world independently and so do not require the protection of their adult caregivers in the same way younger children do. Thus, they do not engage their attachment system as often or in the same manner as younger children. As children age, their psychological world becomes more complex and more challenging to understand. They have had more opportunities for reciprocal interactions, so the motivations of behaviors become less clear. A single behavior may have multiple explanations and the child may be quite unaware of most, if not all, of those motivations. As a result, determining that a child is not checking back with their primary caregiver because of the child’s lack of attachment and not as a result of impulsivity, oppositionality, or a desire to be more independent becomes more difficult, if not impossible. Similarly, an older child may purposefully not seek comfort in times of distress as a result of depression or defiance or simply as an act of differentiation and identity development. In fact, many of the behaviors described in the inhibited type of RAD could be seen readily in a depressed or defiant adolescent.

Terms and Concepts Regarding Attachment Symptoms in Children

Pathogenic care. This term refers to the persistent disregard of a primary caregiver to the child’s needs for emotional comfort, stimulation, and affection; persistent disregard of the child’s physical needs; or repeated changes of primary caregiver, which prevents the formation of dependable and stable relationships (e.g., frequent changes in foster care) (DSM-IV-TR, 2000). The following examples of pathogenic care could be, but are not necessarily, associated with pathological attachment behavior in the child:

- Tyree, age 2, has been in seven foster homes since birth.
- George, age 3, lived his entire life in an under-staffed orphanage, with no primary caregiver and frequent staff turn-over.
- Ranisha, age 4, lived with her parents who had substance abuse disorders, physically abused her, and prostituted her sexually.

Attachment. The concept of attachment represents the central concept in the diagnosis of Reactive Attachment Disorder. In the AACAP Practice Parameters, Zeanah and Boris (2005) describe attachment as “the organization of behaviors in the young child that are designed to achieve physical proximity to a preferred caregiver at times when the child seeks comfort, support, nurturing, or protection. Typically, a preferred attachment to one or two caregivers appears in the latter part of the first year of life and is evidenced by the appearance of separation protest and stranger wariness” (p. 1207). These authors point out that the absence of forming an attachment to a specific person is rare in reasonably responsive caregiving environments. Further, they point out that signs of RAD have never been reported without evidence of serious neglect.

When a child between birth and three years of age is consistently responded to in a caring and sensitive manner and comforted when he/she requires comforting, he/she develops a sense that other persons are available and supportive. Under these circumstances, the child learns that he/she is worthy of love and care and will subsequently develop positive expectations about relationships in general (Ainsworth, Blehar, Waters, & Wall, 1978). In contrast, pathogenically poor caregiving can result in the opposite view of self and others (Hanson & Spratt, 2000). Studies by Spitz (1950), Harlow (1961), and Bowlby (1969, 1980) demonstrated the relationship between profound social deprivation and later psychopathology.

The organization of attachment. Attachment theorists and researchers have identified four normally-occurring types of attachment. These typologies refer specifically to a child’s behavior in the Strange Situation, a laboratory research paradigm (Ainsworth et al., 1978) frequently used to assess the child’s response to the caregiver under increasingly stressful separations from the caregiver arranged in a laboratory setting. The child’s responses in these circumstances are seen as indicating the security that the child finds in the relationship. Child behavior in the Strange Situation is coded as secure, insecure avoidant, insecure resistant, or disorganized. None of these types, even disorganized attachment, are considered to be pathological because in each case, there is a primary caregiver with whom the child can attach in some way. Neither are these categories of attachment considered clinical disorders or indicative of a DSM diagnosis. In turn, Reactive Attachment Disorder is not indicative of a child’s security or insecurity in his or her primary attachment relationships, nor should RAD be confused with any of these attachment patterns. Rather, RAD is a pathology indicating a lack of a discriminate attachment relationship and a lack of consistent demonstration of attachment behaviors to the primary caregiver. The types of attachment security are included here to be informative and to show the range of attachment styles children can exhibit to accommodate their circumstances, but not to suggest in any way that children with an insecure attachment have RAD. Using a

variation of a Strange Situation Paradigm can be very helpful as a component of assessing a child's relationship with a primary caregiver.

Secure attachment. In the secure style of attachment, the child sees the caregiver as a source of safety and comfort and as a base for exploration. Children classified as "secure" explore their environment, monitor the caregiver's proximity during exploration, seek nearness and contact with the caregiver when there is a perceived threat, and find comfort in their contact with the caregiver when distressed (Waters & Valenzuela, 1999.)

Insecure/avoidant attachment. The insecure/avoidant attachment category refers to those children whose Strange Situation behavior indicates that they do not generally seek proximity to the caregiver after separation; they may even appear angry when the caregiver returns after a separation. Although these children explore their environment, they would not, for example, generally appear to actively seek out their caregiver for comfort in a distressful situation.

Insecure/resistant attachment. The insecure/resistant (also referred to as "ambivalent") categorization of child behavior in the Strange Situation refers to children that become highly distressed by their caregiver's absence, but they do not seem to seek comfort with him/her upon reunion. They cannot, apparently, find comfort in their mother's return; and they have trouble recovering from their distress. These children can also behave in an inhibited manner, that is, refrain from active exploration of their environment.

Disorganized attachment. A pattern of disorganized attachment refers to specific behavior in the Strange Situation in which the distressed infant is said to have no organized strategy for approaching the caregiver and eliciting the needed response from the caregiver when he or she (the child) feels threatened. This appears to occur when the caregiver is significantly unpredictable in his or her responses to the infant. In other words, the infant needs comfort from the caregiver, is confused about how to get it, and may give up on the caregiver as a source of comfort. This subset of the insecure attachment classification is the only classification that appears to be linked with later psychopathology (AACAP, 2005). While this pattern is uncommon in the general population (only about 15%), it is more typical in maltreated children (75-80%) (Carlson et al., 1989, Vorria et al., 2003, Zeanah, Smyke, Koga, & Carlson, 2005).

Affective attunement. The process of affective attunement refers to the process by which the mother's/caregiver's activities match the feeling states of the infant in terms of intensity and duration; in this way, the caregiver's activities shape the infant's behavior in a manner reciprocal to how the infant's behavior shapes that of the caregiver in a different sensory modality. Affective attunement in this early relationship supports the development of empathy and emotional self-regulation in later childhood and adult life. Without this experience in early life when neuronal connections are developing rapidly, children could have difficulty with empathy and emotional self

regulation in later life. It can, therefore, be a critical aspect of the work in treatment between a young child and their caregivers, if there have been concerns about attachment.

Bonding. The feelings of love and protection that the primary caregiver has toward his or her newborn or newly adopted child comprise the process known as bonding (Hanson & Spratt, 2000.) In this way, the term refers to the feelings of love and attunement that support the caregiver providing safety and security for the young child. The term is considered to be somewhat outdated by attachment researchers. Nevertheless, it is still used in legal and child welfare circles.

Attachment disorder. While “Attachment Disorder” is a term sometimes used interchangeably with Reactive Attachment Disorder by some therapists, the terms are not synonymous. Reactive Attachment Disorder is a recognized diagnosis in the DSM-IV-TR with a specific phenotype that has a growing body of research to support it. The term “Attachment Disorder” is often used by researchers in the field of Early Childhood Relationships (Zeanah and Smyke, in press; O’Connor, et al., 1999; Boris, et al, 2004) when describing the array of disturbances that can arise for children that encompass, but also transcend Reactive Attachment Disorder. The term “Attachment Disorder” is also used quite differently in a specific group of treatment models to reference more global symptomatology, combining elements of RAD with other DSM diagnoses, such as Conduct Disorder, Oppositional Defiant Disorder, ADHD, Anxiety Disorders, and PTSD. There are several symptom lists used for the “diagnosis” of “Attachment Disorder”, all of which contain similar items. An example is the Randolph Attachment Disorder Questionnaire (Randolph, 2000). It becomes confusing when therapists use the more global symptomatology to inaccurately diagnose a child with Reactive Attachment Disorder. This is often the case when pre-adolescents and adolescents are inaccurately diagnosed with Reactive Attachment Disorder because they have a history of pathogenic care and exhibit aggression and hostile social relationships, particularly with their primary caregivers. An older child with that set of symptoms might more accurately be diagnosed with a behavioral disorder or possibly an anxiety disorder. Recognizing that primary relationships are an issue of significant concern, that child also could be diagnosed with a V-code of Parent Child Relational Problem.

For these Guidelines, it is important not to confuse the terminology “Attachment Disorder” with “Reactive Attachment Disorder” as described in the DSM IV-TR and the Deprivation/Maltreatment Disorder of Infancy described in the Zero to 3 Classification System. The definitions and, in some cases, the approaches to assessment and treatment as well as the theories that underpin them, are not the same.

Attachment therapy. According to the recent (2006) Report of the American Professional Society on the Abuse of Children (APSAC) Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems, there is no agreed-upon definition of the general term “Attachment Therapy.” Some clinicians who describe their work as attachment therapy follow the treatment recommendations

described in the Practice Parameters for the Assessment and Treatment of Children and Adolescents with Reactive Attachment Disorder of Infancy and Early Childhood (AACAP, 2005), yet many do not. In an example of the former, many clinicians who work with older children use aspects of Dyadic Developmental Therapy (DDT; Hughes, 1998) or Theraplay (Myrow, 2000) models. While we are not aware of any randomized clinical trials that have been completed to demonstrate efficacy with these models, DDT and Theraplay address many of the factors present for children who have experienced early pathogenic care, including problems with affective and physiological regulation and the need for direct intervention with the parent child relationship to facilitate a more secure relationship. These treatment modalities can be carried out in a manner that addresses the treatment principles recommended for these Guidelines (see below) and also meets the clinical requirements of a calm, sensitive, non-intrusive, non-threatening, patient, predictable and nurturing approach as described by Haugaard (2004). Other clinicians may be practicing more dangerous strategies with children. These strategies will be discussed in more detail in the “controversies” section of this paper.

Other treatment interventions have been developed to address the complex trauma symptoms of affective, behavioral, and physiological dysregulation common in children who have experienced early pathogenic caregiving. The National Child Traumatic Stress Network compiled many of those and rated them according to the evidence provided for their efficacy (<http://www.nctsnet.org>, 2005; see Appendix I). There are other practices, promoted as “Attachment Therapy”, that are incompatible with Attachment Theory and are controversial, and even dangerous. (For details, see controversies section.)

Attachment behavior. A child’s attachment behavior refers to the system within which the child seeks out the parent in times of distress or when pleased with achievements, as well as the parental sensitivity to, acceptance of, and timely response to the child’s needs. This reciprocal interaction results in mutual satisfaction, comfort, and regulation of affect and behavior for both infant and caregiver. The table below, adapted from Zeanah, Mammen, & Lieberman (1993) describes behavioral signs of disturbed attachment in young children and compares those behaviors to more typical attachment-related behavior.

Considerations When Attachment-Related Trauma Does Not Result In RAD

It is certainly possible for children to experience a range of problems with their primary attachment relationships without developing Reactive Attachment Disorder. The discussion below addresses some of those other issues that do not qualify as Reactive Attachment Disorder but are nonetheless problematic.

The Role of the Caregiver

Children who experience trauma at the hands of their caregivers may develop an array of attachment related problems. Attachment research emphasizes the critical role of the

attachment figure (e.g., parent, caregiver) in providing a haven of safety during times of distress and uncertainty for the young child. During traumatic life events, stress and terror will activate that attachment system and the needs and prior experiences therein – regardless of age. Attentive and responsive attachment figures assist the child in stress reduction and coping, potentially mediating a trauma's impact in select ways.

Threat of loss of or actual abandonment by the attachment figure, either physically or emotionally, during child distress can be a source of terror; and this loss of the attachment figure can be conceptualized as 'relational trauma' or 'attachment-related trauma'. This type of relational trauma is considered more significant among younger children.

However, when the attachment figure is the actual source of fear and confusion, the effect on the child should not be underestimated. These children often exhibit signs of disorganized attachment whereby this circumstance provides a dilemma that leaves the child struggling to organize coherent understanding and solution for this paradoxical situation of needing the one that the child simultaneously fears (Main & Hesse, 1990.) The more traumatic the child's experience at the hands of his/her caretaker, the higher the risk to the child's developmental trajectory (for a review of trauma and attachment in children, see Lieberman & Amaya-Jackson, 2005)

Then, for the assessment and treatment of children with histories of trauma, it is reasonable to conclude that the role of the attachment figure in the child's history and the role of the attachment figure in the child's treatment are both of paramount significance, even when those attachment figures are not the same person.

Maltreatment, Trauma, and Mental Health Outcomes

Children with histories of disrupted attachments and pathogenic care are known to be at high risk for a range of mental health difficulties. The same conditions that give rise to RAD also increase risk for many other types of disorders. Many represent the sequelae of traumatic experiences that occur in the context of pathogenic care by primary attachment figures. Maltreatment is perhaps one of the most prevalent examples of pathogenic care, but other examples of what might qualify as "pathogenic" care include secondary manifestations of interpersonal trauma, such as domestic violence or other kinds of witnessed violence involving loved ones. Children who have been raised in under-staffed and impoverished orphanages or who have experienced institutional or hospital care with frequently changing caregivers are prototypical candidates for which the criteria for "pathogenic care" in the early nosology of RAD was developed. Pathogenic care, whether co-occurring with other traumatic life events or not, will activate a biological stress response in very young children. Therefore, for very young children, pathogenic care may in itself be a form of attachment or relational trauma.

Related diagnoses. Within the DC: 0-3 and the DSM-IV TR classification systems, Traumatic Stress Disorder (DC: 0-3), Posttraumatic Stress Disorder,

Disruptive Behavior Disorders (Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder), Anxiety Disorders, and Depressive Disorders (DSM-IV TR) are diagnostic disorders that have been found to be potential outcomes for children exposed to traumatic life events (Ackerman et al., 1998.) As stated earlier, the caregiving relationship(s), the nature of traumatic experiences, and the chronicity of trauma play a critical role in determining how severely affected the child will be in subsequent behavior and relationships.

Complex trauma response. The chronic stress response seen as a result of repeated and pervasive trauma exposure, particularly when the traumatic experiences are perpetrated by the primary caregiver(s) early in life, has been referred to as “complex trauma” as it extends beyond the classic symptoms of PTSD diagnostic criteria and crosses multiple domains of functioning. Here is where attachment theory finds a unique niche in the trauma conceptual framework (Lieberman & Amaya-Jackson, 2005) and where many of the attachment research outcome findings surrounding disrupted attachment overlap with the DSM-IV field studies in the area of Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (van der Kolk et al, 2005). While a separate disorder for DESNOS is not represented in the DSM-IV, there are text references included for the far reaching consequences when trauma is interpersonal in nature. Domains that can be affected by chronic interpersonal traumatic experiences include affect regulation, self-concept, behavioral control, dissociation, attachment, and biological stability (Cook, Blaustein, Spinazzola & van der Kolk, 2003.) Children with these experiences may have difficulties in one or more of the following areas: 1) self-regulation, attachment, anxiety, and affective disorders in infancy and childhood; 2) addiction, aggression, social helplessness, and eating disorders; 3) dissociative, learning, somatoform, cardiovascular, metabolic, and immunological disorders; 4) sexual disorders in adolescence and adulthood; and 5) re-victimization (Cook et al, 2003).

When experienced in the early years in the context of attachment relationships, the impact of trauma and its similarities in appearance to disorganized/disoriented attachment (Lieberman & Amaya-Jackson, 2005) can also be conceptualized within the complex trauma paradigm. Diagnostic considerations are centered around a child’s triggered dysregulation in response to traumatic reminders, stimulus generalization, and the anticipatory organization of behaviors to prevent the recurrence of the trauma symptoms (Spinazzola, Ford, Zucker, van der Kolk, Silva, Smith, & Blaustein, 2005; van der Kolk, 2005). There are a growing number of treatments for these symptoms, some with a solid evidence-base and others that are promising practices with a growing evidence base and currently being implemented and studied for effectiveness across the country. These models can be found on the website of the National Child Traumatic Stress Network (www.NCTSN.org.)

Principles of Diagnosis and Treatment of Attachment Related Disorders

Diagnosis

For children ages 0-6 years, the guidelines set forth in the American Academy of Child & Adolescent Psychiatry's Practice Parameters for the Assessment and Treatment of Children and Adolescents with Reactive Attachment Disorder of Infancy and Early Childhood (2005) represent the current best practice standard. In these guidelines, Boris and Zeanah point out that the application of RAD criteria and central attachment-related behaviors used in the diagnosis is questionable when applied to latency and adolescent youth—given that attachment behaviors manifested at older ages are markedly different than those observed in infants and toddlers. Furthermore, the determination of criteria for RAD depends on a reliable history of the child's early attachment behavior, that is, symptoms must be evident prior to age 5 years. Given that a history of pathogenic care is required for the diagnosis, injury to the attachment system is to be expected; and consequences for the child's mental health may be significant. Although some evidence has emerged that the indiscriminate pattern, but not the emotionally withdrawn pattern, may persist into later childhood (Zeanah & Smyke, In press), it is important to keep in mind that longitudinal data on young children with RAD are not yet available that will allow us to better determine whether RAD-specific symptomatology truly is sustained or changes over time.

Nevertheless, the diagnosis of RAD is sometimes applied to youth (usually traumatized) in older age ranges. In these cases, there is often notable diffusion of the RAD criteria to include symptoms of Disruptive Behavior Disorders, Attention-Deficit Hyperactivity Disorder, Bipolar Disorder, and Post Traumatic Stress Disorder. Hallmark symptoms of Conduct Disorder and Antisocial Personality Disorder, including lack of empathy or conscience, deceitfulness or sneakiness, and shallowness in relationships, are often incorporated into the purported presentation of RAD in children—absent any evidence for their validity in this context (Levy and Orlans, 1999). As a result, diagnostic precision is sacrificed when oppositional/conduct problems are viewed as attachment-disrupted behaviors, an assumption that can be neither proven nor disproven. Rather than utilizing effective treatments for ODD and CD, alternative therapies that have not been adequately tested or given appropriate safeguards are being propagated, with several notable tragic outcomes.

Assessment Guidelines

The assessment of patients, especially older children, with a history of what is seen as pathogenic care should be undertaken with careful consideration of differential diagnosis and comorbid conditions. (See attached Appendix II "Clinical Pathway for the Assessment and Treatment of Children with Relationship Based Trauma") While there are no studies documenting the degree of comorbidity between RAD and other psychiatric diagnoses, maltreatment is known to be associated with problems in emotion regulation, hypervigilance, and withdrawal (Cicchetti, Toth, & Lynch, 1995). Ackerman and colleagues (1998) conducted a study of abused children and reported that the most common diagnoses were Separation Anxiety Disorder, Oppositional

Defiant Disorder, Phobic Disorders, PTSD, and ADHD. RAD would be considered to be a very uncommon diagnostic sequel.

Appropriate diagnosis should also consider factors that may have contributed to pathogenic care in early years, such as parental substance abuse, major mental illnesses, and socioeconomic adversity. These factors present as risk factors for psychiatric disorders in the child through genetic loading for psychiatric illness, prenatal exposure to nicotine, illicit drugs and alcohol, and suboptimal prenatal care. Prenatal exposures and poor prenatal care may contribute to low birth weight and premature birth and subsequently to developmental delays that will confound a RAD diagnosis.

In summary, a thorough assessment for possible RAD includes:

1. Several direct observations of the child with his or her primary caregivers and with unfamiliar adults to provide an understanding of the history of the child's patterns of attachment behaviors with primary caregivers. AACAP suggests the importance of utilizing a relatively structured observational paradigm in order to effectively compare the child's interactions with various people (AACAP, 2005).
2. Collateral history for gathering information about both current and historical attachment behaviors and exposures to traumatic events in early years.
3. Assessment of the child across settings (such as at school) in order to determine the extent of any problematic behaviors. Behavioral difficulties that are specific to a particular environment will require understanding of whether the problem is specific to that environment or whether the child is responding to a more global level of distress triggered by specific environmental cues, such as a traumatic reminder that may require a very different treatment modality.
4. Psychological testing is an important adjunct in assessing both primary and co-morbid psychiatric disorders. Well validated and reliable broad-band behavioral measures such as the Child Behavior Checklist (Achenbach, 2001) or the Behavioral Assessment Scale for Children (Reynolds and Kamphuis, 1993) are recommended. In addition, a trauma screen and a PTSD assessment measure can be useful, although selection of measures must involve careful attention to the age for which a given instrument has been validated. In assessments of younger children, semi-structured interview formats that focus on trauma exposure and symptomatology may serve as valuable supplements to an assessment (Stover & Berkowitz, 2005). With older children (ages > 8 years) and their caregivers, the University of California Los Angeles Posttraumatic Stress Disorder Index for DSM IV (UCLA PTSD-RI; Rodriguez, Steiberg, & Pynoos, 1999), can be down-loaded free of charge and hand-scored from the web site www.NCTSNet.org. The Trauma Symptom Checklist for Children, which assesses trauma symptoms in children ages 8-17 (Briere, 1996) provides a somewhat broader overview of both PTSD and other trauma related symptomatology, while the related Trauma Symptom Checklist for Young

Children can be used to assess children in the three to 12-year-old range (Briere, 2005). Further, a measure such as the Parenting Stress Index (Abidin, 1995) can be useful for assessing parents' level of distress in the relationship with the child. In addition, the Disturbances of Attachment Interview (Smyke, Dumitrescu, and Zeanah, 2002) and the Circle of Security Interview (Powell, et al., in press) can also be useful when assessing young children.

5. Screening for developmental delays, fetal alcohol syndrome, speech and language delays, or untreated medical conditions for which maltreated children are at increased risk is recommended (AACAP, 2005). Children with pervasive developmental disorders, including Autistic Disorder and Asperger's Syndrome, also appear to have difficulty with relationships, and autistic spectrum disorders must be ruled out before Reactive Attachment Disorder can be diagnosed. Collaboration with a multidisciplinary team that includes primary care providers, educators, therapists and other mental health professionals may be helpful in establishing diagnosis and treatment goals.
6. Awareness and recognition of cultural issues that may be especially relevant for international or cross-cultural placement. For example, norms about the acceptable amount of eye contact and concepts of appropriate interpersonal space vary across cultures. Chaffin and colleagues (2006) suggest that behavior deviance in one cultural setting may be normative for children in different cultural settings, and children placed cross-culturally may experience adaptive challenges. The culture of a child's orphanage should also be considered as behaviors that appear extremely dysfunctional may have been adaptive in that setting.
7. Assessment, differential diagnosis, and risk/safety assessment related to other psychiatric disorders affecting maltreated children are critical in the diagnosis and treatment planning of RAD. A sample of 776 children followed for 17 years found that adolescents and young adults with a history of childhood maltreatment were three times more likely to become depressed or attempt suicide (Brown, Cohen, Johnson, & Smiles, 1999). A history of physical or sexual abuse, emotional abuse, or emotional and physical neglect has been associated with higher risks of attempting suicide. (Fergusson, Woodward, & Horwood, 2000; Grilo, Sanislow, Fehon, Lipschitz, Martino, & McGlashan, 1999; Thompson, Kaslow, Lane, & Kingree, 2000). At all ages, including toddlers and preschool-aged children, risk assessment must include assessment of the child's current safety within their parent child relationships and with others in the home.

Treatment Guidelines

Parents, caregivers, and clinicians can become desperate as they search for understanding and interventions for children with severe symptoms, particularly those who make it difficult or impossible for the child to live within the family or community. In response to this dilemma, these guidelines propose a model for determining the

important treatment components for Reactive Attachment Disorder and other disorders associated with early pathogenic care. From this perspective, treatment approaches for disturbances related to early pathogenic care, often considered traumatic (see above) are based upon: 1) the central theory of attachment underlying the assumptions of the diagnosis, 2) the central diagnostic criteria, 3) the specific behavioral difficulties and needs of the child and 4) developmentally appropriate goals for changes in relationships and behavior.

Two developmentally-specific sets of treatment principles are provided below. The first set of principles provide a guide for developing an individualized treatment plan for children under age six where a thorough assessment validates a diagnosis of Reactive Attachment Disorder. The second set provide a guide for developing an individualized treatment plan for children over age six where a thorough assessment validates a history of pathogenic care and there are severe behavioral issues that are relationship-based and appear to be related to that early history.

TREATMENT PRINCIPLES for YOUNG CHILDREN (< 6 years of age) with Reactive Attachment Disorder.

Treatment principle #1. A child with RAD requires a stable, safe, nurturing and loving primary caregiver. There are two important pieces to achieving this. The first is that the caregiver must be able to be sensitive to the child's signals, but at the same time be able to gently challenge the child's miscues and misperceptions that nurturance is not needed when in fact it is. The second piece is to address the ongoing challenge of this task with the caregiver by providing the support necessary to insure that the placement remains stable. This is no easy task as these children feel very rejecting to their caregivers and the natural instinct is to respond by allowing the child to reject the caregiver. A therapist must be able to provide support to the caregiver and guidance in this area in order to overcome the child's miscues and help them learn how to understand and communicate their needs more directly and effectively. The Attachment and Biobehavioral Catch-up Intervention (Dozier, 2002) and Circle of Security (Hoffman, Marvin, Cooper and Powell, 2006) are two evidence based models that address caregiver sensitivity, but others exist as well. If the child does not have a stable primary caregiver, securing one should be the very highest priority. Therapists can be important advocates and educators for children, assisting those charged with the responsibility of placement of these children by informing them of the critical nature of stable placement, versus allowing children to be placed with multiple caregivers.

Treatment principle #2. Treatment goals should include the following strategies:

1. Enhancing the child's understanding emotions, social cues, and interpersonal situations, which would also be addressed with the treatment interventions mentioned in principle #1.
2. General and specific behavior management interventions that include addressing the issues of interacting appropriately and safely with strangers, as well as, checking in with and seeking out primary caregivers in times of need. Much of this can be addressed through behavioral management programs

- such as Parent Child Interaction Therapy (Eyeberg and Boggs, 1989), or those developed by Webster-Stratton (1993), Barkley (1987) or Forehand (1981). A common goal of each approach involves an emphasis on the nurturing, empathy building, and affective attunement by the caregiver while also offering consistent behavioral consequences would be the goal.
3. Affect regulation skills and impulse control can be effectively addressed through a number of evidence based or evidence informed treatment interventions, including Child Parent Psychotherapy (Lieberman and Van Horn, 2005). Child Parent Psychotherapy, developed from the dyadic work of Selma Fraiberg with mothers and infants, provides trauma treatment to the caregiver and child together through play by focusing on eight core components: (1) developmental guidance, (2) concrete assistance with problems of daily living, (3) assistance to parents in providing safety to children, (4) assistance to parents in learning how to recognize when their children are frightened and when to offer reassurance, (5) translating the meaning of children's behavior to their parents, (6) helping parents understand their child's experience of trauma, (7) helping the parent and child talk about and/or engage in play around the trauma experiences, and (8) talking with the parent and child together about the traumatic events. Cognitive behavioral therapy adapted for young children (Scheeringa, 2007) also addresses these issues.

Treatment principle #3. The child's traumatic history and the child's felt experience in early pathogenic care should be addressed directly if the child is experiencing traumatic stress symptoms as a result of that traumatic history. This direct focus on traumatic stress is important for children of any age, even very young children, where trauma symptoms such as hyper-arousal, avoidance and re-experiencing are evident. These guidelines recommend that the child's early trauma as well as other assaults on self by pathogenic care, if they are remembered by the child, be addressed in treatment models that promote reassurance and behavioral coping with the distress that accompanies painful memories done with the support and involvement of the primary attachment figure. In two prominent models involving treatment of child traumatic stress among preschool-aged children (Lieberman et al, 2005; Scheeringa et al., 2007), intervention strategies include the use of play, physical contact, and language to promote healthy exploration, contain overwhelming affect, clarify feelings, and correct misperceptions; the provision of developmental guidance and information; modeling of appropriate protective behaviors; emotional support and guidance with effective communication; and crisis intervention, case management, and concrete assistance with problems of living.

Cautious focus on past trauma is an important step. If the clinician or caregiver avoids talking about the child's early experiences then this can imply confirmation for the child that certain things cannot be spoken; avoidance then interferes with the child being able to put early experiences in their place in the past and to understand that the blame is not theirs. On the other hand, it is also important to take care that the clinician is not providing information about past trauma to the child that the child is not already

aware of, as that can induce trauma symptoms that were not heretofore present. Teasing out what is unknown from the avoidance associated with PTSD requires clinical skill and judgment, along with caregiver feedback.

Treatment principle #4. Even if considered in the context of addressing traumatic experiences, it is not recommended that children be told their biological parents did not love them or were bad people. Children tend to internalize such messages and conclude that they themselves are bad or unlovable. Research in the field of resiliency has demonstrated that children have better outcomes psychologically if they believe they are lovable and worthwhile in spite of parental abuse or neglect. It can be more useful to help young children understand that their biological parents did not know how to parent them.

TREATMENT PRINCIPLES FOR CHILDREN > AGE 6 are described below to provide a guide for developing an individualized treatment plan for children over age six where a thorough assessment validates a history of pathogenic care and there are severe psycho-behavioral issues that are relationship based and appear to be related to that early history.

Children older than age six are more difficult to diagnose with Reactive Attachment Disorder for reasons described previously. What's more, even in instances of a current or prior diagnosis of RAD, other more disturbing or troublesome behaviors often have evolved and require attention more urgently. Many of the treatment principles for these children are the same or similar to the ones described for younger children. They have been restated below for clarity.

Treatment principle #1. Any treatment plan and intervention must address first the child's needs for safe, dependable, predictable, and responsive caregiving. The core criteria for the diagnosis of RAD indicates that the child or youth has significant disturbances in relationships with others—peers and adults, caregivers, and others. Relationships are disturbed across settings; and they are disrupted by the child's prior learning about relationships, that is, learning that relationships are not safe, not responsive, and not trustworthy. Indeed, some children learn that caregiving relationships are dangerous.

The goal is for the child to gain new learning about relationships, especially from caregivers that can then be generalized to other significant relationships. Intervention models that address learning in the context of relationships vary by the age of the child and by the level of care needed to assure safety (e.g., home vs. group care.) [Optimally, especially for younger children, the key treatment is the caregiver who can become a secure base of love and support for the child. In many cases, the child and caregiver(s) need family treatment from a clinician who understands the child's behaviors and needs and can facilitate strategies for the caregiver keeping the child safe while providing a secure, consistent, and trustworthy base within which the child can develop new models for being in relationships. Helping parents with specific,

evidence based behavior management strategies will be crucial to insure safety and stability for the entire family.

An older child may not meet criteria for RAD when presenting for care, but may have suffered from pathogenic care or present with another primary psychiatric diagnosis that includes characteristics of RAD. Older children, who often present with a broader array of symptoms, including those related to posttraumatic stress, also need a caregiving context that is responsive, dependable, loving, and consistent. This can occur in family or group care but is still highly dependent on the presence of supportive, nurturing, and healing relationships with a primary caregiver or a group of significant and stable caregivers. Models used to map out these types of interventions are described in Appendix I. Given the fact that children with attachment-related difficulties can develop comorbid psychiatric conditions as they age, addressing these issues as early in the child's life as possible is likely to have the most positive results. These present treatment guidelines emphasize that the most important intervention for young children diagnosed with RAD and who lack an attachment to a discriminated caregiver is for the clinician to advocate for providing the child with an emotionally available attachment figure.

Treatment Principle #2. The second focus of treatment is to address the child's traumatic history and the child's felt experience in early pathogenic care. This direct focus on trauma is important for children of any age, even very young children, where trauma symptoms such as hyper-arousal, avoidance and re-experiencing are evident. These guidelines recommend that the child's early trauma as well as other assaults on self by pathogenic care, if they are remembered by the child, be addressed directly in treatment models that also promote behavioral coping with the distress that accompanies painful memories. Evidence based treatment models such as Trauma Focused Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2006) and Child Parent Psychotherapy (Lieberman and Van Horn, 2005) help the child to contextualize and make meaning of their experiences.

This focus on past trauma is an extremely important step. If the clinician or caregiver avoids talking about the child's early experiences then this can confirm for the child that certain things cannot be spoken; avoidance then interferes with the child being able to put early experiences in their place in the past and to understand that the blame is not theirs. **On the other hand**, it is also important to take care that the clinician is not providing information about past trauma to the child that the child is not already aware of, as that can induce trauma symptoms that were not heretofore present. Teasing out what is unknown from the avoidance associated with PTSD requires clinical skill and judgment, along with caregiver feedback.

If the child older than approximately age five does not have a memory of their pathogenic care and/or does not have PTS symptoms, then revisiting the trauma directly through a trauma narrative is not indicated. In those cases, support and education about the traumatic event in order to decrease stigma, enhance safety skills, and foster cognitive and behavioral coping skills may be more beneficial to the child.

Treatment Principle #3. If a child is exhibiting unsafe or high-risk behaviors, such as suicidality or sexual acting out, those behaviors must be addressed immediately and directly and should not wait until parent child relationship-focused work is completed. Specific disturbing behaviors frequently accompany attachment-related problems. It is important to intervene intentionally and directly with these problematic behaviors so the child can be more fully integrated with family and peers (who will, subsequently, provide the secure base for the child.) These behaviors will not go away on their own, but they can be identified and targeted with evidence based treatment models. There are an array of specific behaviors that must be addressed before the child can be safe to self and others. One such behavior is sexual acting out, often a consequence of child sexual abuse. Sexually inappropriate behaviors, even those that involve perpetrating on other children, can be treated directly, specifically, and successfully with evidence-based cognitive behavioral approaches, such as those delineated in the Report of the ATSA Task Force on Children with Sexual Behavior Problems (2006). This report can be downloaded from the Association for the Treatment of Sexual Abusers website at www.atsa.com.

Another symptom that needs to be addressed directly in a treatment plan is suicidality, requiring thorough diagnosis and safety planning during the time of treatment in which the child learns that life is, in fact, worth living. Suicidal intent and thoughts of hurting others are not uncommon in children who have been without safety in their own caregiving. Risk should be evaluated in an ongoing way, and specific safety planning instituted and revised as needed. Safety planning alone is not always adequate; often, the child must be kept safe. Physical aggression also needs to be addressed and can be effectively managed with strategies incorporated in many cognitive-behavioral interventions.

Treatment Principle # 4. The role of psychopharmacologic agents in the treatment of RAD should be adjunctive to empirically validated or evidence informed psychotherapies. There have been no psychopharmacologic trials for RAD. Co-morbid conditions such as ADHD, mood disorders, and anxiety disorders may warrant psychopharmacologic assessment and treatment in order to increase the likelihood that the psychological treatment is successful. Symptom specific treatment with psychotropic medications for severe emotional dysregulation is suggested if benefits outweigh risks of using medications. Parents need psychoeducation about specific target symptoms that medications are meant to alleviate and should be assisted to develop realistic expectations about the risks and limitations of medications in treating disturbing behaviors.

Summary of treatment principles. The treatment plan for a child with attachment related disorders or symptomatology will include the provision of a therapeutic environment of safe and secure caregiving based on the principles of what children need in an attachment relationship. The treatment plan should also address directly, via an evidence based model, the child's prior traumatic experiences and posttraumatic stress symptoms. The other components of a treatment plan address specific

behaviors that interfere with safety and with the aim toward developing the relationships so critical to re-learning about healthy and dependable relationships.

The Use of Evidence Based Treatment Approaches

The importance of evidence based and goal driven approaches whenever available can not be overemphasized. Standards of care for medical conditions such as diabetes or hypertension, for example, are developed based on comprehensive review of available literature, prioritizing evidence from randomized controlled trials. Similarly, practice parameters for the treatment of childhood psychiatric disorders summarize available evidence and make recommendations for treatment based on scientific evidence and expert opinion. The American Academy of Child and Adolescent Psychiatry has published practice parameters for ADHD (1997), Anxiety Disorders, (1997), Autism (1999) Bipolar Disorder (1997), Conduct Disorder (1997), Depressive Disorders (1998), Post Traumatic Stress Disorder (1998) and Reactive Attachment Disorder (2005), all of which can be downloaded at www.aacap.org.

In the absence of a well-validated treatment approach, alternative treatments with sound theoretical bases and broad clinical acceptance are appropriate (Chaffin et al., 2006). For example, a meta-analysis by Bakermans-Kranenburg, van Ijzendoorn and Juffer (2003) found that children's attachment security was most improved by interventions that focused on parental sensitivity to the child. Improving environmental stability, parental sensitivity and other positive qualities of the parent child relationship, responsiveness to children's physical and emotional needs, consistency, and a safe and predictable environment are the keys to improving secure attachment and healing of insecure and disorganized learning about caregiving relationships (Chaffin, et al, 2006; AACAP, 2005). In addition to insuring that the child has a safe and nurturing primary caregiver, foci of treatment must include enhancing understanding of social cues and situations and emotion understanding. These are the domains that should be high priority in a treatment plan for a child diagnosed with RAD.

Controversies in Diagnosis and Treatment

Controversies surrounding the diagnosis and treatment of Reactive Attachment Disorder involve 1) concerns about the safety of some treatment models that have been referred to as "attachment therapy;" 2) the discrepancy between developmental attachment theory (e.g., Bowlby, 1982) and many so called "attachment therapies;" 3) concern regarding the assessment procedures used to diagnose Reactive Attachment Disorder from the "attachment therapy" framework; and 4) concerns about the lack of scientific evidence for the effectiveness of "attachment therapy" interventions derived from this framework.

Issues about Safety

In April 2000, 10-year-old Candace Newmaker, an adoptee from North Carolina, died in Colorado in the presence of her adoptive mother during a two-week intensive

“attachment therapy” program. Candace was smothered in a blanket for 50 minutes during a session captured on videotape. She was, reportedly, receiving treatment for Reactive Attachment Disorder. Five other children have also died as a result of attachment therapies. Subsequently, in 2005, the American Academy of Child and Adolescent Psychiatry warned, “interventions designed to enhance attachment that involve non-contingent physical restraint or coercion...have no empirical support and have been associated with serious harm, including death” (AACAP, 2005; p. 1216). This warning should be heeded and adhered to by all practitioners.

Theoretical Controversies

Although these coercive treatment approaches are most often referred to as “attachment therapy,” they are not based on the theory of human attachment and the extensive literature about parent and child relationships that have developed from this work. Although therapists who use these techniques often refer to Bowlby’s (e.g., 1982) attachment theory as the underpinnings of their work, the theory and techniques are more closely related to Rage Reduction Theory, which holds an entirely different set of assumptions about the behavior and needs of a child (Zaslow, 1975). The promoters of this theory argue that when infants’ needs consistently go unmet, they develop a psychic “core of rage” (2005, 1997, p. 10) that must be incited and released in order for the child to heal and be able to develop a secure relationship with a caregiver. The approach asserts that secure attachment must be developed through pain, fear, and domination over a child instead of the mirroring, attentive, responsive care that Bowlby and others describe as the essential criteria for development of attachment security.

Assessment Controversies

There are a number of assessment procedures, including Single Photon Emission Computed tomography (SPEC) scans, that claim to diagnose RAD, yet none of these procedures is supported by scientific evidence. Examining a child’s “cross-crawlability” (watching the competency with which a child, even a significantly older child, crawls) is another technique said to support a RAD diagnosis; but, again there is no scientific support. Checklists and questionnaires, such as the Randolph Attachment Disorder Questionnaire (Randolph, 2000) are erroneously purported to be reliable and valid measures of Attachment Disorder. The RAD-Q, as it is known, does not in fact, correspond to the DSM-IV diagnosis of RAD; and a diagnosis of “Attachment Disorder” does not exist in any accepted diagnostic code. Importantly, the RAD-Q references symptoms of a number of psychiatric diagnoses, including Oppositional Defiant Disorder, Pervasive Developmental Disorder, and various other behavioral problems. In the Practice Parameters (AACAP, 2005), the American Academy of Child and Adolescent Psychiatry (AACAP) emphasizes that clinicians unfamiliar with Pervasive Developmental Disorder and other neurological conditions may confuse those symptoms for symptoms of Reactive Attachment Disorder. It is the position of these guidelines that the RAD-Q is not sufficient to diagnose Reactive Attachment Disorder and may, in fact, misdiagnose the disorder.

Consistent with best practices, the assessment for Reactive Attachment Disorders must include “direct observation of the child in the context of his/her relationships with primary caregivers” (AACAP 2005; p. 1212) versus only having a parent complete any questionnaire. In addition, many therapists with theoretical roots in the Rage Reduction model argue that the child only has conflict with the primary caregiver and functions well and appropriately in other settings. In contrast, the DSM-IV-TR specifically notes that the inappropriate social relatedness must be evident in most contexts (2000).

Intervention Controversies

Much of the controversy around interventions appropriate for Reactive Attachment Disorder relates back to the discordance of “attachment therapy” with clinical practice based on the principles of developmental attachment theory described earlier. Regarding the latter, clinical care of children with attachment related difficulties focuses on the need for safety, trust, and comfort with caregivers for the development of secure attachment and on the treatment specific to disorganized attachment. These discrepancies among clinical practices for RAD and application of what has become known as “attachment therapy” to solve problems or behavior disorders that have alternative empirical support and conceptually sound practice parameters of their own have been identified as areas of concern by child psychiatrists (American Association of Child and Adolescent Psychiatry; AACAP; see www.aacap.org), professionals in child maltreatment (American Professional Society on the Abuse of Children; APSAC; <http://apsac.fmhi.usf.edu>), and the Office of Victims of Crime within the U.S. Justice Department (OVC; www.ovc.gov).

Furthermore, substantial controversy surrounds an extreme stance by some Rage Reduction therapy proponents who claim that “the unattached child literally does not have a stake in humanity. They do not think and feel like a normal person.” (Thomas, 2005, p. 10) These therapists argue that traditional therapies don’t work for these children. Unfortunately, this point of view may have an intuitive appeal to parents and caregivers who feel like they have tried everything and been thwarted by the child with attachment related problems. The belief that these children are so different from the rest of humanity may explain the extreme nature of the interventions and their acceptance by parents. There is demonstrated danger (both physical and psychological) in these “attachment therapy” methods; and, in addition, there is no empirical evidence of effectiveness. Instead as mentioned above, evidence-based, goal-oriented, behaviorally focused models that emphasize the role of the parents are the most successful across childhood disorders (Weisz, Weiss, Han, Granger, & Morton, 1995), including Reactive Attachment Disorder.

Consideration for Levels of Care

In some circles, a diagnosis of RAD raises questions about the appropriate level of care for a given child, and costly, specialized residential treatment centers that describe their facilities as specializing in the treatment of so-called “attachment disorders” have become as widespread as they are well-known. Despite their sometime popularity and

their seeming responsiveness to the concerns of overwhelmed and frustrated families, level of care decisions remain fundamentally different from ones related to treatment modality.

Within the context of any treatment program, providers should first rely on evidence based, and then, promising practices with strong empirical support for their effectiveness. In making general decisions about levels of care, ranging from outpatient case management or psychotherapy to inpatient hospitalization or secure residential care, clinicians should follow the principles related to assessment, diagnosis, and intervention specified throughout this document.

Regardless of a potential diagnosis of RAD, children should receive care in the least restrictive environment possible that fosters their participation and that of their caregivers and family members in treatment, while ensuring their physical safety. While a diagnosis of RAD would not facilitate an inpatient treatment approach, other conditions which an older child may develop as a result of early pathogenic care might. Decisions about secure settings, such as inpatient or residential psychiatric care, should be based primarily on the child's need for a secure setting due to risk to self (e.g., suicide risk), risk to others (e.g., potential for assaultiveness), or serious incapacitation that interferes with safety (e.g., severe psychosis that compromises basic judgment).

Level of care decisions are usually based on clinical evidence of significant risk, often combined with a pattern of treatment failure in less intensive settings. Several efforts have been made to better standardize level of care recommendations and decisions. For example, the American Academy of Child & Adolescent Psychiatry and the American Association of Community Psychiatrists (2003) developed the Child and Adolescent Level of Care Utilization System (CALOCUS) as a decision making tool about level of care decisions for psychiatrically and behaviorally disturbed youth. The CALOCUS includes six assessment domains related to 1) risk of harm; 2) functional status; 3) medical, addictive and psychiatric comorbidity; 4) recovery environment; 5) treatment and recovery history; and 6) engagement in services. Children are rated along these dimensions to arrive at one of six recommended levels of care: a) recovery maintenance and health management; b) low intensity community-based services; c) high intensity community-based services; d) medically monitored nonresidential services; e) medically monitored residential services; and f) medically managed residential services.

The state of North Carolina relies on the North Carolina Support Needs Assessment Profile (NC-SNAP) to determine intensity of service need related to development disability (Hennike, Michael, Myers, Alexander, Realon, Rodney, & Thompson, Thomas, 2006). The NC-SNAP identifies child needs related to daily living, health care, behavioral supports, and overall psychosocial functioning in an attempt to better match these needs with interventions of an appropriate intensity. The CALOCUS and NC-SNAP represent but two efforts that relate to improving the consistency and quality of decision-making about children's care. Along with other methods, they represent an effort to standardize and improve decisions about children's care in a manner that

lessens the impact of theoretical and clinical perspectives that are not supported by empirical evidence.

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Appendix I



NCTSN Empirically Supported Treatments and Promising Practices

(Listed Alphabetically, with Level of Evidence*)

Treatment and Developer Site	Level of Evidence*	Description
Abuse-focused Cognitive Behavioral Therapy for Child Abuse Western Psychiatric Institute and Clinic Pittsburgh, PA	Supported and Probably Efficacious	↓ Parent to child aggression, abuse risk ↓ child to parent aggression & externalizing behaviors, less family conflict & greater cohesion Clinic or alternative residential setting Age: school age
Attachment, Self-Regulation, and Competence (ARC): A Common-Sense Framework for Intervention with Complexly Traumatized Youth The Trauma Center Allston, MA	Promising and Acceptable	↓ Trauma symptoms ↑ attachment(s), regulatory capacity, competency, and systems of care implemented in school, community, or clinic settings All ages
Child-Parent Psychotherapy for Family Violence Early Trauma Treatment Network San Francisco, CA	Well Supported and Efficacious	↑ parent child relationship ↑ IQ, ↓ child behavior problems ↓ child PTSD symptoms, ↓ symptoms of anxious attachment, ↓ maternal PTSD Clinic or home setting Age: infants, toddlers, and preschoolers
Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse NJCARES Institute UMDNJ-SOM Stratford, NJ	Supported and Acceptable	↓ PTSD, depression, abuse-related attributions, & externalizing behavior problems in children. ↓ Parental anger, behavior management skills, parent to child violence, & parent-child relationship. Children, ages: 4-17, and caregivers
COPE-Community Outreach Program National Crime Victims Research and Treatment Center Charleston, SC	Supported and Acceptable	↓ Trauma symptoms TF-CBT, PCIT framework + Case management Applied in home, school based settings Age 4-18
Modified Dialectical Behavioral Therapy with Developmentally Disabled Children Aurora Mental Health Center Aurora, CO	Novel and Experimental	↓ Trauma symptoms ↓ Emotion & Behavior Dysregulation Age:10-14

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Multimodality Trauma Treatment (MMTT) Center for Child & Family Health/Duke University Durham, NC	Supported and Acceptable	↓ PTSD ,depression, anxiety, anger group therapy (or individual) School, clinic, residential settings Age: 9+
Parent-Child Interaction Therapy Sheila Eyberg, PhD, University of Florida Gainesville, FL	Supported and Probably Efficacious	↑ parenting skills ↑ parent child relationship ↓ child externalizing behaviors ↓ parent to child physical abuse age: 4 – 12
Real Life Heroes Parsons Child Trauma Study Center Albany, NY	Supported and Acceptable	↓ Loss, violence, neglect, abuse, complex trauma ↑ placement, safety, attachment, affect regulation, skill building, creative arts, life story work CBT components, & psycho-education Age 6-13, adaptable for adolescents
Safe Harbor Program: A School-based Victim Assistance & Violence Prevention Program Safe Horizon New York, NY	Supported and Acceptable	↓ Trauma symptoms ↑ parent involvement Includes school wide campaign Age 6-20
Sanctuary Model Jewish Board of Family and Children's Services Westchester, NY	Supported and Acceptable	↑ Emotional Regulation Psycho-education Therapeutic community Residential Treatment : age 6+
Sanctuary® Plus (IRIS Project) Community Works, Philadelphia, PA; Parsons Child Trauma Study Center, Albany, NY; Jewish Board of Child and Family Services, New York, NY; Andrus Children's Services, Yonkers, NY	Promising and Acceptable	Residential treatment for traumatized children Integrated model of Sanctuary, START, & Real-Life Heroes Age: 6+
Skills Training in Affective & Interpersonal Regulation/Narrative Story Telling (STAIR/NST) The Institute for Trauma & Stress at NYU Child Study Center New York, NY	Supported and Acceptable	↓ PTSD symptoms ↓ anger, dissociation, depression, internalizing, & externalizing behavior ↑ Social competency & emotional regulation Age: 12-21
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) Adolescent Trauma Treatment Development Center, Division of Child and Adolescent Psychiatry, North Shore University Hospital, Manhasset, NY	Supported and Acceptable	↓ Symptoms resulting from chronic traumatic stress ↑ Social competency & emotional regulation Group Treatment (based on CBT and DBT) Males and females; Age 13-21
Trauma Adaptive Recovery Group Education & Therapy for Adolescents and Pre-Adolescents (TARGET) University of Connecticut Farmington, CT	Promising and Acceptable	↓ Trauma symptoms ↑ Emotional Regulation Community, School or residential juvenile justice settings Age: 10-18
Trauma-Focused Cognitive Behavioral Therapy Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents, Pittsburg, PA & New Jersey CARES Institute	Well Supported and Efficacious	↓ Child PTSD symptoms, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. ↑ parenting practices
Trauma-Focused Cognitive Behavioral Therapy for Childhood Traumatic Grief Allegheny General Hospital Center for Traumatic Stress Pittsburgh, PA	Supported and Probably Efficacious	↓ Trauma & grief symptoms Clinic, school, community setting Age 6-17
Trauma Systems Therapy Boston University Medical Center Boston, MA	Supported and Acceptable	↓ Trauma symptoms ↑ Emotional Regulation ↑ system of care stabilized social environment Age: 6-18

* Level of Evidence is based upon published, peer-reviewed data (provided by developers as of 17 February 2005) using the accompanying treatment classification criteria utilized by the “Office of Victims of Crime Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse.” Full version available at www.musc.edu/cvc/guide1.htm. Summary version available at www.NCTSNet.org. The Fact Sheets that accompany this table may also include *unpublished* data, which are not considered in the assigned Level of Evidence.

↑ = Increases
↓ = Decreases

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Appendix II

Clinical Pathway for the Assessment and Treatment of Children with Relationship-based Trauma

