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Jennifer Lawrence  
*St. Catherine University*

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Effective Practice Based Therapeutic Techniques with Children Diagnosed with Reactive  
Attachment Disorder: From the Perspective of Mental Health Professionals

Submitted by Jennifer R. Lawrence  
May, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work  
St. Catherine University & University of St. Thomas  
St. Paul, Minnesota

Committee Members:

Dr. Felicia Sy MSW, PhD., LICSW (Chair)

Pamela Baker, MS, LISW, LMFT

Paul Buckley, LMFT

## Table of Contents

Section	Page
I. Abstract	3
II. Introduction and Research Question	4
III. Literature Review	9
A. Critique of the Literature	21
IV. Conceptual Framework	25
V. Methods	29
A. Research Design	29
B. Sample	30
C. Protection of Human Subjects	31
D. Data Collection	32
E. Data Analysis Plan	33
F. Strengths and Limitations	34
VI. Findings	36
VII. Discussion	59
VIII. Conclusion	62
IX. References	63
X. Appendices	
A. Schedule of Interview Questions	66
B. Interviewee Consent Form	67
C. Participant Recruitment Flyer	69
D. Recruitment Telephone Script	70
E. Recruitment E-mail Form	71

## ABSTRACT

Children diagnosed with Reactive Attachment Disorder (RAD) have experienced pathological care and disruption of early attachment experiences, resulting in disorganized attachment with caregivers, as well as a myriad of complex symptoms and behaviors. Little research exists regarding effective treatment for children diagnosed with RAD, leaving both mental health professionals and caregivers wanting. The purpose of this qualitative study was to explore effective treatment for children diagnosed with RAD through the lens of mental health professionals. Seven experienced mental health professionals were interviewed regarding their perceptions on effective therapeutic treatment that contributes to increased attachment bonds with caregivers and decreased RAD symptoms. Analysis of the data revealed key themes, which were organized into a theory representative of an effective therapeutic process. Findings demonstrated an overarching conceptual framework of Attachment Theory emphasizing the core themes of theory and research, professional competency, assessment and evaluation, an attuned therapeutic dyad, and community collaboration. These key themes may contribute to increased attachment bonds between children and their caregivers, as well as resolve of symptoms. Future research that addresses and refines these critical components is necessary for prevention, effective treatment, increased professional competency and decreased societal stigmas towards children diagnosed with RAD and their caregivers.

## Introduction

The purpose of this qualitative study was to explore the perceptions of mental health professionals in regards to effective treatment of the difficult symptoms and behaviors of children diagnosed with the clinical disorder of Reactive Attachment Disorder (RAD). Children with RAD have experienced pathological care and/or the disruption of attachment, resulting in a disorganized attachment system (Becker-Weidman, 2006; Becker-Weidman, 2008). Little research exists regarding effective treatment of RAD and there are currently no empirical studies addressing effective evidence based practice (Lieberman, 2003). Despite limited research, treatment of RAD is of grave concern to mental health professionals and caregivers due to the prevalence of children who have experienced abuse and neglect alongside disrupted attachments with their primary caregivers. Children with RAD can be difficult to care for due to the severe and sometimes disturbing behaviors and symptoms (Lieberman, 2003; Perry, 2001). Caregivers and professionals may find themselves feeling inadequate in their abilities, lacking in effective and supportive resources, and experiencing feelings of hopelessness and frustration (Lieberman, 2003). Children, parents and mental health professionals would benefit greatly from increased research and education regarding effective, safe, ethical and empirically supported therapeutic practices.

The research explores effective practice based methods that mental health professionals have found to be successful in decreasing RAD symptoms and behaviors as well as increasing attachment bonds with primary caregivers. The overall research question presented is:

“What specific therapeutic techniques have mental health professionals found to be successful in decreasing symptoms of RAD and increasing attachment bonds with primary caregivers?”

This question was formulated from existing research exploring therapeutic methods that reportedly had success in decreasing RAD symptoms and increasing attachment bonds with primary caregivers (Becker-Weidman, 2006; Marvin, Cooper, Hoffman & Powell, 2002; Wimmer, Vonk & Bordnick, 2009). The hope is to theorize possible treatment recommendations through the uncovering of key elements that can assist caregivers beyond the mere management of behaviors of children with RAD, to a path of long-lasting hope and healing (Lieberman, 2003; Perry, 2001).

This proposal will first discuss the prevalence of pathological care, followed by the consequences and effects of disrupted attachments and pathological care (Becker-Weidman, 2008). RAD is defined and discussed, followed by a literature review and exploration of the conceptual framework of Attachment Theory. Research methods and findings will be discussed and explored, followed by a final discussion regarding future implications.

Child abuse and neglect continues to affect the lives of thousands of children each year and has become a pervasive problem within the United States (Horner, 2008). In September of 2010, the Adoption and Foster Care Analysis and Reporting System (AFCARS) reported 408,425 documented children in foster care in the United States, 107,011 of which were permanently separated from their primary caregivers and awaiting adoption (US Department of Health and Human Services Administration for Children Youth and Families, 2008). This is alarming, considering that 67% of these children were placed in adoptive homes following multiple placements in foster care at an average stay of 4 to 5 years (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2010). According to Child Welfare Information Gateway (2004), 10-25% of adoptions disrupt or dissolve due to significant barriers to securing

affordable and supportive services. Children that are older and have had multiple foster placements are especially vulnerable to disruption due to increased needs and severity in symptoms and behaviors (Child Welfare Information Gateway, 2004). Clearly, child neglect, abuse and separation from primary caregivers are not a rarity. The consequences of pathological care, ruptured attachments, multiple caregivers and lack of permanency is concerning due to the large numbers of children who experience such. These children are at an increased risk for psychopathology and possibly the eventual diagnosis of a childhood disorder, such as that of Reactive Attachment Disorder (RAD) (Becker-Weidman, 2008; Horner, 2008).

Reactive Attachment Disorder (RAD) is one of many childhood disorders that may result from early maltreatment, trauma and separation from caregivers (Becker-Weidman, 2006; Becker-Weidman & Hughes, 2008). Children that suffer maltreatment and disruption of care face neurological consequences, such as an inhibited ability to regulate their emotions and cope with distress (Gearity, 2005; Perry, 2001). Children without the ability to regulate their emotions have difficulty mentalizing, organizing their experiences and developing a coherent sense of self (Becker-Weidman, 2006; Dozier, 2003; Slade, 2005). Significant trauma may result in dysregulation and dissociation in times of distress (Becker-Weidman, 2006; Becker-Weidman & Hughes, 2008; Dozier, 2001). These children are at high risk for depression, anxiety, post-traumatic stress disorder and reactive attachment disorder (Becker-Weidman & Hughes, 2008). Severe disorders such as conduct disorders or personality disorders may result if such children are left untreated (Becker-Weidman, 2008; Dozier, 2003; Horner, 2008). They may experience social isolation, rejection, low self-esteem, learning difficulties, increased aggression and harmful behaviors towards self and others (Becker-Weidman, 2006; Becker-Weidman & Hughes, 2008, Lieberman, 2003). Further developmental delays may impact speech, language and the

ability to communicate effectively (Becker-Weidman, 2006; Perry, 2001; Schore & Schore, 2001). Children that experience such delays have high needs and are often difficult to care for because of the social, emotional and cognitive consequences of their experiences (Becker-Weidman, 2006; Becker-Weidman & Hughes, 2008; Lieberman, 2003). These factors increase the risk for further neglect and removal from primary caregivers, foster homes or potential adoptive families (Child Welfare Information Gateway, 2004; Becker-Weidman, 2006). Clearly, children that suffer significant maltreatment and disrupted attachments are a vulnerable and high-risk population that faces increased risk for psychopathology, which may in turn lead to the eventual symptoms and diagnosis of RAD (Becker-Weidman, 2008).

According to the American Psychiatric Association (APA), RAD is a clinical disorder that is evidenced by a history of pathogenic care that involves “persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection” and/or “persistent disregard of the child’s basic physical needs” and/or “repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care)” (2000, p.78). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), RAD is usually first diagnosed in infancy or early childhood and is a:

Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2):  
‘Persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions’ or ‘diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments.’  
(APA, 2000, p. 78-79.)

Children and adolescents with RAD may present with inhibited type symptoms such as hypervigilance, ambivalence, avoidance, frozen watchfulness and resistance to comfort from their caregiver (APA, 2000; Becker-Weidman & Hughes, 2008). Children with disinhibited type symptoms may present with poor boundaries such as “excessive familiarity with relative



strangers” (APA, 2000, p. 78). Children and adolescents diagnosed with RAD have difficulty forming healthy relationships, relating to others socially and attaching securely to a primary caregiver (Becker-Weidman & Hughes, 2008; Horner, 2008; Perry, 2001). Overall, children with RAD suffer significant social, emotional and psychological delays due to pathological care and disrupted attachments with primary caregivers (APA, 2000; Becker-Weidman & Hughes, 2008).

This does not assume that all children who suffer maltreatment and interruption of attachment bonds will qualify for the diagnosis of RAD. The frequency and prevalence of RAD remains a mystery due to the fact that RAD is the least researched and least understood diagnosis in the DSM IV (Becker-Weidman, 2006). Richters and Volkmar (1994) estimate that less than 1% of children in the general population will present with symptoms of RAD (Boris and Zeanah, 2005). According to various studies involving high-risk children in foster care or institutionalized settings, the percentage of children with symptoms of RAD increases anywhere from 38% to 40% (Boris and Zeanah, 2005). Becker-Weidman (2006) reports that 50-80% of the adopted children in a study of treatment for children with trauma-attachment disorders presented with symptoms of RAD (Boris and Zeanah, 2005). The prevalence of RAD is difficult to determine with certainty and is outside of the scope of this proposed study. This does not diminish the importance and urgency of research that strives to further understand the diagnosis and explore effective treatment strategies.

Possible treatment strategies and elements reported as critical to therapeutic success are presented in the literature review, followed by an explanation of the conceptual framework of Attachment Theory. The methods section explains the process that was used to gather, organize and analyze incoming data. The data was gathered using semi-structured, open-ended and

audiotaped interviews with mental health professionals. Respondents were trained and experienced in the treatment of children with histories of trauma as well as symptoms or diagnosis of RAD or attachment disturbance. Interviews were transcribed and coded through the use of Grounded Theory methodology and the analysis technique of constant comparison. Codes were narrowed into categories, which were then organized into developing themes and an overarching theory. Overall, the purpose of this study is to explore effective practice based therapeutic methods for children with RAD, through the gathering of various perspectives and experiences of mental health professionals with experience in treating children with RAD.

### **Literature Review**

Empirically based research regarding effective treatment of RAD is limited, leaving professionals and caregivers discouraged (O'Connor & Zeahna, 2003). No particular treatment has proven effective in treating RAD and literature ranges in perspective regarding recommended approaches based on the child's history of trauma, environment, presenting symptoms and co-morbidity (O'Connor & Zeahna, 2003). Traditional and modern treatments typically stem from developmental psychology and Attachment Theory (O'Connor & Zeahna, 2003). According to various studies, interventions based in Attachment Theory have been moderately effective with high-risk parents and children with RAD or attachment disturbances (O'Connor & Zeahna, 2003). These interventions primarily look at the quality of the attachment style of the parent-child dyad in developing a course for treatment (O'Connor & Zeahna, 2003; Lieberman, 2003). The focus of treatment becomes the relationship between the child and the primary caregivers. The main goal is to improve parental responsiveness and attunement, which in turn assists the child in the achievement of appropriate developmental tasks and the

development of a trusting and secure base (O'Connor & Zeanah, 2003). Attachment-based approaches vary widely, however, certain elements appear to be critical to attachment-based treatment. Proposed practice parameters for recommended treatment approaches with children diagnosed with RAD are explored below, followed by three therapeutic modalities inclusive of attachment-based elements. Common key themes drawn from the literature are then presented and analyzed.

### **Proposed Practice Parameters**

The American Academy of Child and Adolescent Psychiatry (2005) proposed practice parameters concerning the diagnosis and treatment of RAD (Boris & Zeanah, 2005).

Recommendations included a thorough assessment of the child-parent dyad attachment relationship followed by the provision of a safe and stable environment with an emotionally attuned and available caregiver (Boris & Zeanah, 2005). Another important recommendation is the restructuring of the child's internal working model through the provision of positive interactions with caregivers that provide for a corrective experience (Boris & Zeanah, 2005).

These themes, though broad, were found within several studies exploring the treatment approaches of Dyadic Developmental Psychotherapy (DDP), Circle of Security (COS), as well as Attachment Therapy (AT) (Becker-Weidman, 2006; Marvin et al., 2002; Wimmer et al., 2009). The findings of these studies demonstrate that these key elements may contribute to decreased symptoms and increased attachment bonds. Each study is outlined below, followed by a description of common key themes.

Becker-Weidman's (2006) study on the effectiveness of Dyadic Developmental Psychotherapy (DDP) on children with trauma attachment disorders and their families, integrated

all of the above core themes. DDP is an attachment-based therapy that was developed by Daniel Hughes (Becker-Weidman, 2008). DDP uses attachment strategies that assist in altering the caregiver's state of mind in order to increase attunement, caregiver co-regulation and reflective functioning (Becker-Weidman, 2008). It emphasizes the education of the caregiver in the child's psychological and behavioral problems that resulted from the loss of a consistent attachment figure (Becker-Weidman, 2008; Lieberman, 2003; Perry, 2001). DDP has been seemingly effective in altering parental perceptions of the child through the provision of child-focused developmental guidance and support (Becker-Weidman, 2008; Lieberman, 2003). The findings of this DDP study demonstrate significant decreases in RAD symptoms of 34 children ages 5-17 years of age that were treated weekly with DDP. The control group consisted of 30 subjects that received various modalities of outside treatment not inclusive of DDP. Subjects receiving DDP demonstrated a significant increase in attachment bonds compared to the control group, which demonstrated no significant changes or progress (Becker-Weidman, 2006). Improvements that were made were maintained for at least 4 years following the study (Becker-Weidman, 2006). The findings suggested that DDP was an effective therapeutic strategy for this sample population.

The Circle of Security Project, (COS), is another attachment-based intervention that focuses on repairing disrupted attachments between high-risk caregivers and their high-risk children (Marvin et al., 2002). The goal of this study was to develop evidence based intervention procedures that could be used by community-based practitioners and professionals to repair disrupted attachments (Marvin et al., 2002). The sample size consisted of 75 dyads made up of six small groups consisting of at-risk primary caregivers along with their children, which ranged between the ages of 1-4 years in age (Marvin et al., 2002). Treatment consisted of 20 weeks of 1 hour and 15 minute sessions of psychotherapy (Marvin et al., 2002). The goal of treatment was

for the children to successfully internalize their parents as a secure base, while increasing their ability to manage overwhelming affect without dysregulation (Marvin et al., 2002; Slade, 2005). The Circle of Security model was developed from Mary Ainsworth's concept of the need for the caregiver to act as an emotionally receptive and attuned caregiver that allows the exploration of the child while they remain available as a secure base (Marvin et al., 2002). The process of repair represented by the Circle of Security incorporated the above key themes, similar to, but different than DDP, as outlined below (Becker-Weidman, 2006; Marvin et al., 2002).

These similar key themes were also found present in a study measuring the effectiveness of Attachment Therapy (AT) (different than attachment-based therapy) on children with RAD that were adopted (Wimmer, et al., 2009). This study involved a sample size of 24 adopted children who were living with their adoptive families (Wimmer, et al., 2009). The goal of the study was to determine whether or not attachment therapy decreased RAD symptom severity and improved the child's functioning within the family (Wimmer, et al., 2009). This study was funded by a public-private partnership with Attachment Therapy for Adoptive Children with Special Needs and was funded through the Georgia Office of Adoptions (Wimmer, et al., 2009). This research was done out of a response to requests from adoptive parents with children with attachment disturbances in need of additional treatment resources (Wimmer, et al., 2009). The intervention process involved five therapy teams over a period of 3 years (Wimmer, et al., 2009). Children received 10 hours of AT with therapists trained by Children Unlimited of South Carolina. This training involved a yearlong series of monthly seminars consisting of parent education about Attachment Theory, the effects of abuse and neglect, Parenting Skills Training (PST) and intensive family therapy (Wimmer, et al., 2009). The results indicated that RAD

symptoms decreased significantly following treatment and that there was improvement in overall family functioning (Wimmer, et al., 2009).

### **Assessment and evaluation**

No common protocol currently exists for the diagnosis and assessment of attachment disorders (O'Connor & Zeahna, 2003). However, a thorough assessment and evaluation process was emphasized for each family in each of the above studies.

DDP assessment and evaluation involved the completion of the Randolph Attachment Disorder Questionnaire (RADQ) and the Child Behavior Checklist (CBCL) prior to and following treatment (Becker-Weidman, 2006). Extensive examinations of records and psychological tests were reviewed in order to assess the current attachment relationship between the primary caregiver and child (Becker-Weidman, 2006). The assessment involved observing the primary caregiver's ability to engage in an emotionally attuned relationship and to measure changes (Becker-Weidman, 2006).

The evaluation and assessment process of COS involved the evaluation of the parent-child dyad's interactions in regards to risk and resilience while creating goals specific to the dyad (Marvin et al., 2002). This process included participation in Mary Ainsworth's Strange Situation, a videotaped interview using specific portions of the Parent Development Interview (PDI), as well as selected portions from the Adult Attachment Interview (AAI) (Marvin et al., 2002). Parents were required to fill out several standardized questionnaires regarding symptoms and behaviors seen in the child and information regarding current stresses (Marvin et al., 2002). The purpose of the assessment and evaluation process was to measure shifts in the quality of the attachment relationship post treatment (Marvin et al., 2002).

The study evaluating Attachment Therapy (AT) demonstrated the use of a thorough evaluation and assessment process (Wimmer, et al., 2009). The RADQ, Child And Adolescent Functional Assessment Scale (CAFAS), Preschool And Early Childhood Functional Assessment Scale (PRECFAS), Personality Inventory for Children (PIC), CBCL and the Millon Adolescent Personality Inventory (MAPI) were used as measurement tools both prior to and post therapy (Wimmer, et al., 2009). The child's mother completed the measurements and provided information regarding demographics during the initial interview (Wimmer, et al., 2009).

Clearly, an in-depth, intensive and on-going evaluation and assessment process were common themes among these studies and may be factors that contributed to the reported success of these three attachment-based treatments.

## **Education**

The intervention process of these studies involved the common theme of parental education, or training and involved the active participation of the primary caregiver. The education and participation of the caregiver was seen as instrumental to changing patterns in the attachment relationships of participants and facilitating healing within the relationship (Becker-Weidman, 2006; Marvin et al., 2002; Perry, 2001; Wimmer et al., 2009). The training and education of professionals was also a common theme in each modality and an important piece to effective and consistent therapy.

DDP emphasized the education and participation of primary caregivers throughout the entire therapeutic process (Becker-Weidman, 2006). The initial phase of treatment involved the education of caregivers through the modeling and teaching of attunement and responsiveness to the child's expressed or observed needs (Becker-Weidman, 2006; Slade, 2005). Attunement was taught through the use of the acronym "PLACE" in order to educate parents on the importance of

their ability to be “Playful”, “Accepting”, “Curious” and “Empathic” to the child (Becker-Weidman, 2006; Slade, 2005). “PLACE” was used to facilitate the creation of a secure base with the caregiver, and laid the groundwork for the provision of a corrective experience where the child’s needs were met consistently. Therapists who provided services were trained in DDP methods prior to the implementation of treatment services. Clearly, DDP emphasized education of both caregivers and mental health practitioners.

COS incorporated education into the therapeutic process through the recording and reviewing of videotapes. Recordings consisted of parent-child interactions and were viewed alongside therapists and support group members (Marvin et al., 2002). The educational process involved both the teaching and modeling of appropriate child-caregiver interactions (Marvin et al., 2002). Parents were educated on Attachment Theory, attachment behaviors and were taught how to recognize and respond to their child’s attachment initiating cues (Marvin et al., 2002). Therapists were certified in COS to ensure competency in assessment, treatment planning and application of Attachment Theory (Marvin et al., 2002).

AT also emphasized the importance of educating primary caregivers. Parents were educated on Attachment Theory and the effects of maltreatment. Therapists both modeled and taught parenting skills and the importance of the emotional attachment bond between child and caregiver (Perry, 2001; Wimmer, et al., 2009). AT not only emphasized the importance of education for caregivers but also for clinicians (Wimmer, et al., 2009). Therapists attended three days of intensive trainings monthly for a period of 9 months (Wimmer, et al., 2009). The trainings were given by a variety of attachment therapists, namely Daniel Hughes, Ph. D and Gregory Keck, Ph. D. (Wimmer, et al., 2009). Therapists received additional training in Eye Movement Desensitization and Reprocessing (EMDR) and Neurofeedback Therapy (Wimmer, et



al., 2009). Therapists were also required to attend the Association for Treatment and Training in the Attachment of Children conference (ATTACH) (Wimmer, et al., 2009). Clearly, education was an important part of AT for both primary caregivers as well as professionals.

The therapeutic modalities utilized in the above studies, DDP, COS and AT, all demonstrated the importance of education in treatment. Education of parents was critical to successful therapy as parents learned how to be attuned and responsive caregivers in response to their child's need for a secure base. Education and training of professionals was important in order to ensure consistency and quality of therapeutic processes. Education of both primary caregivers and professionals seemed to play a key role in the successful outcomes of these studies.

### **Attuned Therapeutic Dyad**

An attuned therapeutic dyad seemed to play an important role in each of these studies. The therapeutic dyad consisted of the relationship between the therapist and child, therapist and caregiver and caregiver and child. This relationship was the vehicle that both taught and modeled the importance of an emotionally attuned caregiver and created the opportunity for the creation of new meaning and overall corrective attachment experience.

DDP emphasized the role of an attuned therapeutic dyad through the use of the acronyms of "PACE" and "PLACE". "PACE" represented the therapist's ability to be "playful", "accepting", "curious" and "empathic" (Becker-Weidman, 2006). These elements facilitated the process of creating a positive emotional connection between the caregiver and child (Becker-Weidman, 2006). The therapeutic relationship addresses any mis-attunement between the child and caregiver. Attachment is facilitated through the therapist's and the parent's abilities to co-

regulate affect and use reflective capacities (Becker-Weidman, 2006). The context of an attuned therapeutic dyad allows both child and parent to learn how to recognize and regulate their emotions (Becker-Weidman, 2006). This leads to increased self-awareness and the ability to make sense out of memories, representations and affect (Becker-Weidman, 2006; Slade, 2005). “PACE” also teaches the child to use the therapist as a secure base, which in turn models to the parent how to be a secure base for the child (Becker-Weidman, 2006). The use of “PACE” facilitates a relationship of trust between child and therapist, therapist and caregiver, and caregiver and child through the modeling of an attuned and available therapist (Becker-Weidman, 2006). The therapeutic dyad and the therapist’s use of self are emphasized as key to the therapeutic success of DDP (Becker-Weidman, 2008).

COS also refers to the importance of a strong therapeutic dyad (Marvin et al., 2002). The main focus of therapy remains on the caregiver-child relationship, however the process of creating a strong attachment relationship first occurs through a therapist that is attuned and available to both the child and parent (Marvin et al., 2002). COS is unique in that a parental support group is included as part of the therapeutic dyad (Marvin et al., 2002). The support group and therapist serve as coaches in affect regulation and the re-enactment of a healthy attachment cycle (Marvin et al., 2002). The parent and child cannot learn affect regulation and mentalization without the therapist’s ability to teach and model emotional attunement and receptivity (Marvin et al., 2002). Similar to DDP, the therapist becomes a secure base for both child and parent while the parent learns attunement and co-regulation (Marvin et al., 2002). The therapist facilitates the shift in the caregiver’s state of mind and perception of the child, alongside the child’s state of mind and perception of the parent (Lieberman, 2003; Marvin et al., 2002; Slade, 2005). Clearly, COS emphasizes the importance of an attuned therapeutic dyad in

the provision of a corrective experience for the child and parent.

The strength of the therapeutic dyad is an important part of AT, however not as evident as in DDP and COS. The therapist is considered the main vehicle for education and change in the attachment relationship through the modeling and teaching of attuned responsiveness (Wimmer, et al., 2009). AT emphasizes Family Focused Therapy that focuses on behavioral and discipline concerns, as well as the child's interpretation of past events (Wimmer, et al., 2009). AT is unique in its emphasis of using holding therapy in order to facilitate bonding between the therapeutic dyad, while significant emotions are talked about and worked through (Wimmer, et al., 2009). Holding therapy involves the laying of the child on the lap of the therapist or parent, while encouraging positive eye contact and discussion of past abuse connected with affect (Wimmer, et al., 2009). Holding therapy emphasizes nurture from the caregiver and is different than holding therapy that is coercive, such as that of the controversial rage reduction or rebirthing (Wimmer, et al., 2009). AT is also unique in its incorporation of other therapeutic methods such as EMDR and Narrative Therapy (Wimmer, et al., 2009). The therapist serves as a secure base for both child and parent as the parent learns attunement, receptivity and the importance of acting as a secure base that the child can turn to when experiencing a need (Wimmer, et al., 2009). Again, this secure base facilitates the development of affect regulation, mentalization and the incorporation of past hurts into a working narrative that leads to a corrective experience (Wimmer, et al., 2009).

An attuned therapeutic dyad is a common theme among these studies and seems to play an important role in successful outcomes. The therapeutic relationship serves as a vehicle for the creation of new meaning and overall corrective attachment experience through the use of an attuned and receptive therapist and caregiver acting as a secure base for the child.

## **Corrective Experience**

As mentioned earlier, DDP, COS and AT focus on the importance of a thorough assessment, education and an attuned therapeutic dyad. These elements pave the way for a corrective experience for both child and caregiver. The hope is that through education and a strong therapeutic dyad, caregivers will learn how to be a secure base for the child. The caregiver's attunement and responsiveness increases the child's sense of safety, security and trust in the child-parent relationship. This sense of security, safety and trust is evidence of a corrective attachment experience (Perry, 2001; Schore & Schore, 2001).

DDP emphasizes the importance of an attuned caregiver and facilitates a corrective experience through interventions that focus on building a secure attachment between child and caregiver (Becker-Weidman, 2006). DDP uses attachment-facilitating techniques of various kinds that include cognitive behavioral strategies and restructuring for both child and parent (Becker-Weidman, 2006). DDP incorporates eye contact, physical touch, tone of voice, cognitive restructuring, psychodramatic reenactments and the incorporation of developmental needs in a healthy attachment cycle (Becker-Weidman, 2006). The goal of the attachment activities is to increase the child's feeling of safety and feeling of being understood by their caregiver (Becker-Weidman, 2006). The child's increased safety, alongside the therapist's and caregiver's ability to reflect back the child's perceived thoughts and feelings, aides in the child in their ability to regulate emotions, mentalize and make sense of past experiences within the context of the relationship (Becker-Weidman, 2006). The creation of a healthy attachment cycle through affect regulation, mentalization and the re-experiencing of affect associated with previous trauma are critical components of DDP (Becker-Weidman, 2006). This cycle allows for the repair of a distorted inner working model and the development of a coherent sense of self

(Becker-Weidman, 2006; Slade, 2005). New meaning is created for the child within the context of past trauma (Becker-Weidman, 2006). Finally, the child is able to communicate their new understanding to the caregiver and the child's behaviors are integrated into a chronological narrative (Becker-Weidman, 2006). This creation of new meaning is the culmination of the repair process and appears critical to the increase in caregiver-child attachment bonds and resolve of RAD symptoms (Becker-Weidman, 2006).

COS also lays the groundwork for a corrective experience through parental education that promotes attachment through attunement and the creation of a secure base. Parents reenact the COS attachment cycle which encourages attunement and responsiveness to the child's attachment and exploratory signals (Marvin et al., 2002). This attachment cycle is referred to as an "adaptive attunement-disruption-repair" which aides the child in their ability to regulate their emotions, maintain proximity to their caregiver and encourages the caregiver to remain attuned to their child's experiences and feelings (Marvin et al., 2002). The creation of new meaning for the child develops from the parent's attunement and responsiveness as they reflect back to the child their inner and subjective experiences (Marvin et al., 2002). This on-going dialogue alters defenses and increases empathy and understanding of the child's internal world (Marvin et al., 2002). Through such a process, the child develops a greater ability to explore their environment with the increased knowledge and trust that their caregiver is close by (Marvin et al., 2002). This ability to experience their caregiver as a secure base increases the child's ability to regulate emotions, reflect on their experiences and make sense of their experiences in light of the new attachment relationship (Marvin et al., 2002). This corrective attachment experience increases the child's self-concept and will hopefully pave the pathway to future self-actualization (Marvin et al., 2002; Slade, 2005).

AT also aims to provide for a corrective experience through the modeling and repetition of a healthy attachment cycle in which the caregiver acts as a secure base (Marvin et al., 2002). AT focuses on intensive bonding through the use of holding therapy, as mentioned above (Marvin et al., 2002). This use of holding therapy is differentiated from controversial holding therapies involving coercion, rage reduction, re-birthing, or physically intrusive interventions (Dozier, 2003; Marvin et al., 2002). The caregiver and therapist act as a secure base throughout the incorporation of EMDR, Narrative Therapy, and Holding therapy. This seemed to contribute to the creation of positive and corrective attachment experiences with the caregiver.

Clearly, Dyadic Developmental Therapy, the Circle of Security project and Attachment Therapy share common themes that may contribute to the successful therapeutic outcomes of children diagnosed with RAD. These themes involve a thorough assessment and evaluation, education of both primary caregiver and therapist, an attuned therapeutic dyad, and the provision of a corrective experience. A thorough evaluation and assessment process reveals the child's internal model of attachment alongside the parent's state of mind toward the child (Gearity, 2005). Education promotes the creation of an attuned, receptive, and responsive therapeutic dyad. An attuned therapeutic dyad creates a safe, secure and trusting holding environment, which provides the child with a corrective experience and relationship repair (Slade, 2005). Clearly, these three studies overlap in their use of the mentioned core themes in order to increase attachment bonds and decrease RAD symptoms.

### **Critique of the Literature**

These studies of various treatment strategies of children with RAD demonstrate common themes that further our knowledge of what strategies may be effective in the treatment of

children with RAD. The above themes are important for clinicians to not only recognize but to become better educated and trained. The overall contribution of each individual theme to the success of therapy is unknown, however future research can pay particular attention to the role of each theme and how each theme may individually and specifically contribute to success. The above research serves as a possible guide for stimulating ideas for future research.

### **Strengths**

The literature presents with both strengths and limitations. A strength is the fact that key therapeutic elements are overlapping. All of the treatment interventions were based in the conceptual framework of Attachment Theory, though each study varied in application. Another strength is in the various methods and strategies applied. This leaves room for individualization of treatment according to the particular needs of each child and the different aspects of the caregiver-child relationship. Such overlap and variety allows for creativity and flexibility in both the search and application of effective therapeutic strategies for children with RAD.

### **Limitations**

These studies and the themes also presented with limits. The small, non-random sample sizes were from selective and difficult to access populations; making generalization impossible to the larger population (Becker-Weidman, 2006; Marvin et al., 2002; Wimmer et al., 2009). Another limitation might be that of skewed results due to demographic limitations. Many participants were voluntary families, which had been connected to agencies or support systems prior to the study (Becker-Weidman, 2006; Marvin et al., 2002; Wimmer et al., 2009). These samples may not account for families that are socially isolated without access to such intensive

treatment options (Becker-Weidman, 2006; Marvin et al., 2002; Wimmer et al., 2009). Additional factors that are not accounted for entirely are those of age, gender, socioeconomic status, level of education and support, family make-up, cultural differences, severity and longevity of pathological care, and the quality and type of interruptions in attachment experienced. Also, the majority of child participants ranged from 1 to 12 years in age and were not representative of adolescents. Participants consisted of children in foster care or children who were adopted. This study fails to compare children who were in foster care, adopted, institutionalized, in residential treatment programs, or those living with biological or extended family. Also, certain elements regarding family education, knowledge and experience prior to and post therapy remain unexplored. Some families may have had limited financial assistance, a low level of investment prior to treatment, varying resilience, or even varying levels of hope in spiritual and moral beliefs. Finally, the qualities, demographics, and training of the therapists are not explored in great detail.

Another limitation of these studies is that the therapists were associated with one specific agency, organization and/or therapeutic modality. Sample sizes that draw from one agency may result in skewed data because the clinicians may be biased towards the agency's chosen methodology. Little is known about the qualifications of the therapists involved, despite the reference to certain trainings. The individual characteristics and qualities of the therapists that may have contributed to success go unmeasured.

Clearly, the literature presents with both strengths and limitations. These are important elements to keep in mind when looking at future implications and opportunities for further research.



## **Implications**

Implications for further research would include the evaluation of cost effective studies that are capable of drawing from a large, diverse and random sample size. The reviewed studies were representative of only a small portion of children diagnosed with RAD. Valid studies that can be generalized are difficult to come by as they are expensive, difficult to fund and the population is considered vulnerable and difficult to access. Empirically based treatment methods can only be discovered through studies that consist of random and valid sample sizes that are representative of the whole population. Until larger, generalizeable studies are designed and funded, smaller sample sizes and less sophisticated studies will continue to be the main source of research regarding effective practice for treatment of children with RAD. More research is needed in order to increase understanding. Effective treatment of RAD continues to remain a mystery without empirical and evidenced based research.

Future research should promote comparative longitudinal studies that measure long-term successes, as well as short-term successes. Finally, future research should present both strengths and limitations. Literature presented above expressed many strengths but specified few limitations.

In summary, this literature review explored several studies that focused on effective therapeutic treatment strategies with children with RAD and their families. Findings suggested that further research is a necessity. Key elements that seemed critical to successful therapeutic outcomes involved the conceptual framework of Attachment Theory, a thorough evaluation and assessment process, education and participation of primary caregivers and professionals and the development of a strong and attuned therapeutic dyad. Finally, effective therapy provides for a corrective experience through the modeling and repetition of a healthy attachment cycle

encompassing affect regulation, mentalization and the re-experiencing of affect associated with past trauma (Slade, 2005).

### **Conceptual Framework**

The literature review refers to the importance of integrating Attachment Theory, or attachment based interventions, in the treatment of children with RAD. Professionals turn to attachment based therapeutic approaches in order to further understand the development of children with RAD and an appropriate course for treatment. These approaches most often have Attachment Theory and developmental psychology as their foundation. Attachment Theory was chosen as the conceptual framework for this research proposal due to the very nature of the diagnosis of RAD. RAD symptoms develop in response to pathological care or inconsistency in care, and as a direct result from the quality of the attachment relationship with their primary caregiver.

Attachment Theory was first proposed by John Bowlby and further refined with the research of Mary Ainsworth (Association for Treatment and Training in the Attachment of Children (ATTACH), 2002; Perry, 2001). Bowlby proposed that the child had an innate need and survival instinct to stay within proximity to their primary caregiver, as demonstrated through certain attachment behaviors or signals (ATTACH, 2002; Perry, 2001). These attachment behaviors and the ability to stay within close proximity to a primary caregiver promoted the development of a safe, secure, predictable and responsive environment in which the child could develop a healthy sense of self (ATTACH, 2002). He referred to the caregiver as a secure base, which the child could rely upon for safety and security in times of distress (ATTACH, 2002; Perry, 2001). According to attachment expert Daniel Siegel,

Attachment is an inborn system in the brain that evolves in ways that influence and organize motivational, emotional, and memory processes with respect to significant caregiving figures. The attachment system motivates an infant to seek proximity to parents (and other primary caregivers) and to establish communication with them. At the most basic evolutionary level, this behavioral system improves the chances of the infant's survival. At the level of the mind, attachment establishes an interpersonal relationship that helps the immature brain use the mature functions of the parent's brain to organize its own processes (1999, p.67).

In essence, the child's brain organizes itself around the parent's brain and the attachment relationship.

Bowlby also observed that children who experienced threats to attachment and separation from caregivers experienced significant distress and anxiety (ATTACH, 2002; Perry, 2001). Over time, such distress led to despair and the eventual detachment (ATTACH, 2002; Perry, 2001). He hypothesized that such ruptures in attachment left children highly vulnerable to pathological disorders (ATTACH, 2002).

Mary Ainsworth contributed to further development of Attachment Theory in her studies and observations of attachment patterns between children and their caregivers in the Strange Situation Procedure (Perry, 2001). She hypothesized that the attachment relationship between the child and primary caretaker evolves over time (ATTACH, 2002). The type of attachment that forms is dependent upon the emotional availability, attunement, and consistency of the caregiver in their ability to meet the child's needs (ATTACH, 2002; Perry, 2001). She recognized consistent patterns of attachment dependent upon the quality of the attachment relationship (Perry, 2001). These styles of attachment are recognized today in the assessment of attachment relationships and in attachment based therapies (Perry, 2001). These four attachment patterns, or styles, are secure, insecure-resistant, insecure-avoidant, and insecure-disorganized (ATTACH, 2002; Perry, 2001). Children with RAD are most often children that have developed a

disorganized attachment to their caregiver, which is important to recognize in developing a treatment plan (Becker-Weidman, 2008).

Attachment Theory, in essence, is the theory that infants and their primary caregiver, usually their biological mother, develop a life long bond, or relationship, that makes up the building blocks of a child's healthy development (Perry, 2001; Schore & Schore, 2001). This relationship forms in the early stages of infancy and is considered necessary for healthy social, emotional and psychological development (Schore & Schore, 2001). This attachment relationship is dependent upon the quality of interactions with the caregiver as well as on the individual temperaments within their environment (Perry, 2001). A secure attachment occurs when a caregiver provides a nurturing, safe, consistent and secure base to which the child can turn to when in need (Perry, 2001). The threat of the child's loss of an attachment figure results in a state of fear (Perry, 2001; Lieberman, 2003; Slade, 2005). Parents that are abusive and neglectful evoke such fear and disorganization. A child may become confused when the attachment figure, their primary source of safety and security, becomes a source of distress and fear (Perry, 2001; Lieberman, 2003; Slade, 2005). The result is a child that is unable to regulate their emotions and is overwhelmed with feelings of rejection and worthlessness (Lieberman, 2003; Perry, 2001). Attachment problems depend upon the nature, intensity, timing and duration of pathological care, however children who have attachment figures that are inconsistent, punitive and unresponsive, risk many deficits (Becker-Weidman, 2008; Lieberman, 2003). They may be unable to regulate emotions and reflect or make sense of their internal world or the internal world of others (Becker-Weidman, 2008; Schore & Schore, 2001; Slade, 2005). This results in a lack of empathy, poor impulse control, and an inability to recognize the impact of their behavior on others (Perry, 2001).

According to modern Attachment Theorists, neurology plays a large part in the child's ability to regulate their emotions and make sense of their world (Schore & Schore, 2001). The attachment relationship facilitates the child's brain development and the child's brain organizes itself according to the child's attachment relationship (Gearity, 2005; Schore & Schore, 2001). This attachment relationship facilitates the child's bodily-based processes and the interactive regulation, or co-regulation, of affect provided by the caretaker (Schore & Schore, 2001). Simply put, the attachment relationship shapes brain development and the systems involved in regulation of affect and self (Gearity, 2005; Slade, 2005).

Further discovery of the bodily-based processes has shifted towards a regulation theory (Schore & Schore, 2008). Parents that are not attuned to their children and do not meet their children's basic needs hinder their child's development of self-soothing skills, and ability to regulate (Schore & Schore, 2001). Their negative experiences from their early years transfers to future relationships and the distrust learned from early caregivers transfers to future caregivers (Lieberman, 2003; Schore & Schore, 2001). These children develop a map of attachment that leads to an inability to trust adults to care for them (Gearity, 2005). The world is deemed a dangerous and insecure place and they believe they are left to fend for themselves (Slade, 2005). The lack of an adult to help them regulate their emotions, interpret their experiences, understand their own mind and the mind of others, results in dysregulation and a dysfunctional internal working model (Perry, 2001; Slade, 2005). According to attachment expert Siegel,

The nature of an infant's attachment to the parent (or other primary caregiver) will become internalized as a working model of attachment. If this model represents security, the baby will be able to explore the world and to separate and mature in a healthy way. If the attachment relationship is problematic, the internal working model of attachment will not give the infant a sense of a secure base, and the development of normal behaviors (such as play, exploration, and social interactions) will be impaired (1999, p. 72).

Children with RAD experience a negative internal working model, which communicates to them that adults cannot be trusted and this can result in the refusal of adult care (Lieberman, 2003). Caregivers are often in a desperate search for affordable and accessible resources and attuned professionals that can offer the wisdom and assistance needed to bring about developmental repair as well as a corrective attachment experience (Lieberman, 2003; O'Connor and Zeahna, 2003). The child can experience a secure base from a therapeutic dyad that is attuned and responsive to their needs. Incorporation of Attachment Theory into treatment provides a basis in which the therapist can initiate this corrective attachment experience.

### **Methods**

Discovery and refinement of effective treatment strategies for children with RAD is the central goal of this study. The overall research question presented is: "What specific therapeutic techniques have mental health professionals found to be successful in decreasing symptoms of RAD and increasing attachment bonds with primary caregivers?"

This question was formulated using the framework of Attachment Theory as well as from existing research regarding Attachment Theory, effective treatment of RAD, attachment disorders, and the effects of maltreatment and trauma. This study further investigates effective treatment strategies through the exploration of the lived practice based experiences and perspectives of mental health professionals.

### **Research Design**

The methodology chosen for this study is that of Grounded Theory (GT) using constant comparison analysis. Data was gathered through audio taped interviews of recruited mental

health professionals with direct experience in working with children with RAD. The interviews were compared and contrasted throughout the data collection process, allowing the data to build upon consecutive data (Glaser & Strauss, 1967). The data was transcribed verbatim and relevant themes were refined through the technique of open coding (Glaser & Strauss, 1967). As data accumulated, properties and dimensions became increasingly transparent (Glaser & Strauss, 1967). The use of semi-structured and open-ended interview questions allowed for the adaptation of questions to fit the needs presented by the transforming data. Constant comparison analysis involved a 6-stage coding and data analysis process described in the data analysis section (Sy, 2010). Following data analysis, emerging themes led to the development of a theory, which consists of the relevant themes found in the conceptual framework, literature and findings (Glaser & Strauss, 1967).

### **Sampling**

This study used theoretical and purposive sampling through two key informant organizations known as ATTACH, or the Association for Treatment and Training in the Attachment of Children (<http://www.attach.org>) as well as MARN, or the Minnesota Adoption Resource Network (<http://www.mnadopt.org>). Mental health professionals were contacted through the publicized lists of mental health professionals associated with these key informant organizations. The goal was to have a purposive sample of approximately 8-10 participants. Potential interviewees were contacted initially by e-mail (Appendix E) with an attached recruitment flyer (Appendix C) and consent form (Appendix B). E-mails were followed by a telephone inquiry (Appendix D) in order to confirm interest and availability, answer interviewee questions, address concerns and inquire about potential referrals for additional participants. The

final purposive sample of therapists consisted of seven mental health professionals. They voluntarily agreed to participate in a semi-structured, open-ended, audio taped and confidential interview following verbal consent and review of the final consent form (Appendix B). . They identified as professionals trained and knowledgeable in the areas of attachment and adoption. They were screened prior to the interview for relevant experience and training in working with children diagnosed with RAD, attachment disorders, or with histories of maltreatment or trauma.

### **Protection of Human Subjects**

Participants were protected throughout the research process. Initial contact was initiated by e-mail and phone, however participation was entirely voluntary. Names and identifying information of final participants were kept confidential from both the referral source and the public. Participation in this study required at least 5 years experience working with children with RAD or attachment disorder and an understanding of Attachment Theory. The goal was to obtain a diverse make-up of professionals, with a variety of perspectives and training, in order to draw out common themes without the bias of individual agency or institutional missions. No interviewees were affiliated with the same agency or institution other than that of the key informant organizations. Participants were informed of how and why they were selected, the purpose, the procedures involved, the risks and benefits, ensured confidentiality, and the voluntary nature of this study.

The researcher confirmed each participant's agreement to participate by determining an appointment time and method for the interview. The appointment was confirmed either by an encrypted e-mail or by telephone. No in-person interviews occurred due to the location of final participants. All interviews occurred by telephone.



Prior to the interview, the interviewer was sent an encrypted confirmation e-mail along with the interview questions (Appendix A) and consent form (Appendix B) for the participant's review. The respondent was informed via the consent form (Appendix B) of their rights to protection and reminded of the voluntary nature of the study and opportunity to withdraw. It was made clear that the study had no direct risks or benefits. All records remained confidential. Following the completion of the study and report, the audiotape and transcript were destroyed. The researcher ensured that the interview process took into account the respondent's protection and maintained compliance with the IRB process. Upon approval, the study was publicly presented. The study was published and made available through the University of St. Thomas and St. Catherine University of St. Paul, MN.

### **Data Collection**

A semi-structured interview was conducted involving a questionnaire (Appendix A) with 10 open-ended questions pertaining to effective treatment strategies of children with RAD. These questions were designed and organized around the themes presented in the literature review, specifically addressing education and involvement of the primary caregiver, the strength of the therapeutic dyad, and the provision of a corrective experience through key elements found in Attachment Theory. The first few questions were designed with the intention of building rapport, as well as to gather further information on the education and training of the professional. As the interview progressed, questions became increasingly intense and inquired about the personal experiences of the mental health professionals. The data gathered from the interview questions was audio taped, transcribed, organized, coded, analyzed, discussed, published and presented.

## **Data analysis plan**

The analytic strategy of the researcher involved the use of a qualitative Grounded Theory method of content analysis whereby data was constantly compared while being systematically gathered through audio taped interviews. This process involved gathering and organizing data through the creation of a transcript, followed by an analysis involving the systematic and objective identification of codes using a six phase coding process outlined in Table 1 (Berg, 2009; Glaser & Strauss, 1967; Sy, 2010).

The first phase of this process included open coding, which involved a manifest content analysis whereby the transcription was coded according to the “surface structure”, rather than the latent content. Key variables were identified and compared (Berg, 2009, p. 344; Glaser & Strauss, 1967, Sy, 2010). The second phase involved axial or thematic coding, which involved the creation of broad categories, which developed from key variables specified during the open coding process (Glaser & Strauss, 1967; Sy, 2010). The third phase involved the creation of a coding paradigm, whereby the key concepts were drawn out to create a visual skeleton template from which categories could be focused and narrowed (Sy, 2010). The 5<sup>th</sup> phase involved selective coding, or typology building, where codes and categories were divided into contrasts. Phase six involved the identification of patterns, which formed concepts and clarified an emerging theory (Glaser & Strauss, 1967; Sy, 2010).

An inter-reliability check was performed throughout the constant comparison process in which the transcripts were re-read and re-reviewed while cross-checking the codes, noting interpretations and insights, re-categorizing and combining codes as well as narrowing and condensing themes where necessary (Glaser & Strauss, 1967). Repetitive codes and themes emerged that were both implicit and explicit that were later compared and contrasted with

themes and theories presented in the literature (Berg, 2009).

<b>Table 1. Coding system</b>		
<b>Phase</b>	<b>Code</b>	<b>Description and use</b>
Phase 1	Open Coding	Systematically identifying and comparing key variables
Phase 2	Axial/Thematic Coding	Broad categories that break the information into segments
Phase 3	Coding Paradigm/heuristic concepts	Using existing theoretical concepts to create a skeleton for further analysis.
Phase 4	Code categories or indexing	Open codes (derived from commonsense knowledge and in vivo codes (used by interviewees)
Phase 5	Selective Coding/Typology building	Codes are divided into contrasts or opposites
Phase 6	Concept formation (emerging theories)	Labeling patterns of behavior, stereotypes or processes

Table 1. Summary of Coding Process (Sy, 2010).

### **Strengths and Limitations**

The overall goal of this study was to gain greater insight into the experiences of mental health professionals who have worked closely with children with RAD and their families. The hope is that their training and experience positively contributes to existing research and effective treatment approaches for RAD. The use of a qualitative study using Grounded Theory, constant comparison method, fits well because of the limited information regarding effective practice with RAD. There is a need for greater insight into the lived experiences of those who are working closely with these children. A qualitative study gathered the richness of their training and

expertise through the interview process in a way that a quantitative study would not have been able to do. This study is unique because interviewees were drawn from a sample size that is both purposive but also diverse in terms of agency affiliation and geographical location. Though the professionals are members of ATTACH or MARN, their education, training and experience was diverse in nature. Professionals were located throughout the United States, some of which had intercontinental experience and training. The ability to remain flexible as certain themes began to emerge assisted in the guidance of the researcher to categories, patterns and a theory.

Despite the strengths, limitations remain. A qualitative study provides richness and depth that a quantitative study cannot, however, many would argue that it lacks objectivity and is therefore non-transferable and cannot be generalized to the larger population. Limited time, resources, responses and follow through have limited this study in terms of its scope, sample size, and quality. This study is not a longitudinal study and no follow up study will be done. The unit of analysis is the researcher and the data is words rather than measurable numbers. Unlike quantitative research, qualitative research is not outcome oriented and variables are not controlled. Theory emerges, yet it remains untested. Ultimately, the results of this study will not be considered evidence based practice research because of these mentioned limitations.

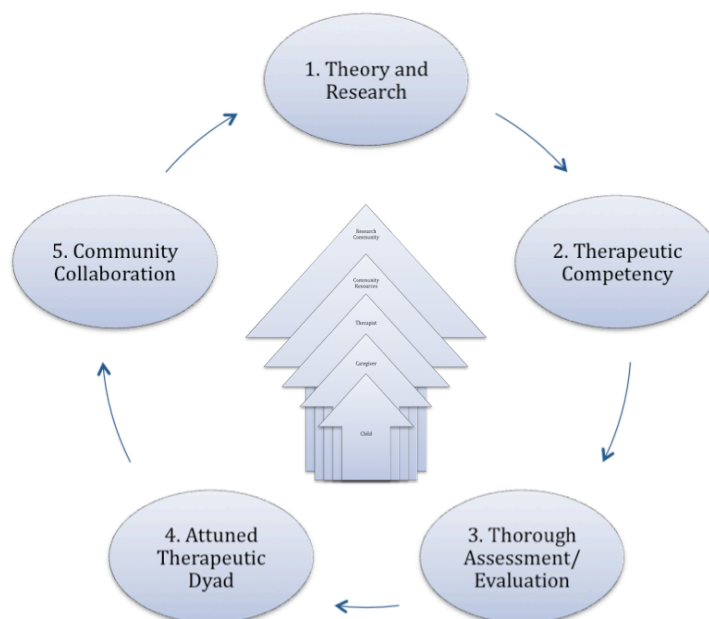
Clearly there are both strengths and limitations to this study, however the strengths outweigh the limitations because the purpose of the study was to gather information regarding multiple realities of mental health professionals from different organizations and regions with a variety of training and experiences. Overall, Grounded Theory constant comparison has allowed the researcher the flexibility and creativity needed to allow the data to naturally transform into theory. The telling of stories and lived experiences of trained and experienced professionals remains a critical aspect of this research. Those who make the important sacrifices of time and

energy to seek out effective treatments for a difficult and wounded population are key to the future development of effective evidence base therapeutic methods for children with RAD.

### Findings

Several significant themes emerged from the data that related to the overall research question, “What are effective practice based therapeutic strategies for children diagnosed with RAD and their families from the perspective of mental health professionals?” The specific goal of this question was to uncover practice based therapeutic elements seen as critical to increasing attachment bonds between children and their primary caregivers, as well to the resolve of RAD symptoms. Themes were organized into a coding paradigm, which represents a theory in an Effective Attachment Based Therapeutic Process. This skeleton, (Table 2), represents an interdependent, theoretically based, therapeutic process which in turn encompasses the therapeutic holding environment referenced in Attachment Theory.

Table 2. Effective Attachment Based Therapeutic Process and Holding Milieu



Essential therapeutic themes found within this theoretical therapeutic process include: theory and research, therapeutic competency, a thorough assessment and evaluation, an attuned therapeutic dyad, and community collaboration. Stationed within these elements is a representation of a therapeutic, attachment-based holding environment. This holding environment depicts not only the child's need for a safe and secure base housed within the caregiver holding environment, but also the therapist's need to be supported and informed by the community of collaborative resources and research community. The holding environment appears critical to the creation of a secure and attuned therapeutic dyad, which in turn allows for the creation of a safe and secure base from the parent for the child. This depiction is referred to as a holding milieu and is a critical structure within the therapeutic process. Themes are further discussed, as well as noted subthemes that emerged from within the individual themes found within this theoretical process.

### **Theory and Research**

Theory and research are reoccurring themes regarding effective practice with children with RAD. Clinicians emphasize the importance of having a strong therapeutic base grounded in both theory and research, which in turn promotes effective implementation of a variety of therapeutic methods conducive to the needs of clients.

A clinician's knowledge and incorporation of Attachment Theory, as well as knowledge in child development, neuroscience and trauma, are seen as essential to the therapeutic process.

*To be a good therapist you have to have a theoretical, of course which is speaking from my own agenda, a theoretical grounding, in why your doing what your doing. So I think essential reading and getting grounded in initial John Bowlby, Ainsworth, Mary Main, Judy Solomon and all of those people that have done some work on what is attachment and people that have done work on early childhood development. I think that's essential training to have as a theoretical base, more than the how to.*

A professional's knowledge of child development is also important in order to recognize developmental deficits and develop a proper treatment plan for creation of a secure base.

*...the other thing that often is involved is really looking at the emotional age of the child. Most of the kids and teens we work with, and I think this is pretty common across the board with early attachment and trauma, so they get stuck at earlier developmental stages and we want to meet them where they are and we want to work with them through that process. As they are starting to feel more secure and more attached, their development striving kicks in and then they can start to function more at their chronological age...*

Knowledge in safety, security, trust, and regulation; elements also found in Attachment Theory and child development, are important to understanding psychopathology and effective treatment, yet this respondent believes many professionals are lacking in this essential understanding:

*I wish that more professionals understood the first and second year cycle, development cycle. That, during the first year, that trust and regulation has been learned and during the second year, that umm, conscience development, regulation, acceptance of authority. A lot of these things lie at the basis of most psychopathology and, the building blocks of child development and attachment. I think a lot of professionals don't have that and should.*

Knowledge of neuroscience, or neuropsychology, and brain research is also imperative to effective therapy:

*Bowlby's discussion of what attachment is, is foundational... and then the new brain research with Alan Schore, Dan Siegel... all the people that have done so much more in brain research; Besser Van der kolk, Bruce Perry, umm those people who continue to do a lot of research on the development of the brain... we now know that that early life brain development and what Bowlby talked about in early attachment are really in harmony with each other and important to look at.*

Again, Attachment Theory and neuroscience are critical to effective therapy:

*A good understanding of not only Attachment Theory, like Bowlby's Attachment Theory, but also all of the work that is coming out on neuroscience...Alan Schore, Daniel Hughes, Daniel Siegel's and Daniel Stern...the three Daniels...Louis Cozzelino...are, um, critical.*

And again in the following:

*Daniel Siegel's work is really, really important; the whole understanding of neuroscience with Bruce Perry, Louis Cozzelino, Alan Schore, is the base of everyone else's work. Everyone else has based their work on Alan Schore, Bruce Perry, and there are a lot of good folks out there.*

A strong understanding of how trauma and attachment problems effect healthy child development is important to effective treatment:

*...kids with early trauma and attachment problems; if you were going to graph out all of the different ages and stages of development and how they function, their graph is going to be all over the place, much more than kids with other issues or of course kids who don't have a mental health condition, so its another theme that I think we need to be aware of.*

Attachment disruptions and trauma are often interrelated and come in a variety of forms:

*Most of clients have a form of early trauma, or attach disorder, or a combination of both... That could be all kinds of numbers of trauma such as separations, neglect, abuse; could be a parent that has some form of mental health or drug and alcohol issues so they are not able to be emotionally available. Could be parent that needed to be hospitalized for some reason, but you do need to have some form of causal factor to have a child or a teen that is diagnosed with attachment disorder.*

### **Methods**

A significant subtheme of theory and research is the specific methodology that is recommended for treatment. Common methods that incorporate theory and research that clinicians incorporate into therapy include DDP, EMDR, Theraplay and Narrative therapy:

*General good clinical skills...good child development, good basic trauma experience, Theraplay; a wonderful model...Theraplay training or activities; there are a lot of good modalities...good Narrative Therapies, EMDR, DDP... So I think you have to find out some about them and find the one that seems to match.*

In regards to essential therapeutic methods, one interviewee refers to the importance of DDP because of its necessary component of parental involvement, which is again reiterated in the theme of attuned dyad:



*...certainly DDP. One of the reasons, well, there's lots of reasons that DDP is absolutely essential and one is that I don't think you can do effective attachment work without an attachment figure in the room.*

Though integration of theory, research and various methods are recommended, with a particular emphasis on DDP and Theraplay, there is also an awareness of the limitations of traditional therapies. There is a continuing need for on-going research and specialization of treatment methods in order to meet individual needs and ensure client protection from harm:

*Understanding that traditional therapy can be used, but there does need to be some specialization in terms of modalities for parenting and for therapy that has sometimes rubbed other professionals the wrong way... tried for many, many years to do traditional therapy, and some did very well and some were getting worse...the harm is that for years of traditional therapy and not creating positive change for the family (which makes treatment in and of itself more difficult) now having more ingrained harm in waiting... now we have a situation that is even going to be harder to repair.*

There is currently no evidenced based practice that is recommended for RAD. Respondents caution that methods and strategies that are applied should consider the child and caregiver's individual needs. There is no cookie cutter approach and taking such an approach could be harmful:

*Things are not as evidence based as we would like to have, so we have insurance companies that ask why aren't you using CBT? When it fits, I'll use it, but not when a child isn't regulated at all and can't have a relationship with the parent... so you have to be willing to think outside of the box.*

### ***Diagnostic Delineation***

Another significant subtheme to theory and research is that of effective diagnostic delineation. The clinician's understanding of theory and integration of research effects their ability to recognize and accurately diagnose RAD. There is much confusion and disagreement regarding how to diagnose effectively and consistently. In order to facilitate therapeutic models

that are effective and research based, diagnostic differentiation should be further clarified within the clinical community:

*The diagnostic piece, for PTSD and RAD is really difficult because there is not an agreement on what an attachment disorder is and how does attachment and trauma really intertwine...we need more clarification about what kids are falling into this pattern and therapeutic modalities that are being used...more research so we can say this is evidence based...here and there are small outcome studies. So, not enough out there and we're trying to go against the grain and don't have a study out there that can say 'take a look at this'... makes it much more difficult to buy into this...we need that backing.*

Children can be very complex and clinicians must be able to diagnose and treat overlapping and complex symptoms effectively, that may be overlooked with current diagnostic criteria:

*I will be honest that one of the things that I want to be sure that I get a chance to say today an I now you are open to whatever I'd like to include is that the diagnostic criteria in the DSM IV are so, just so poorly delineated, that it really is difficult to do an accurate diagnosis based on those criteria. Most of us who specialize in the field use more specific diagnostic criteria in symptoms and patterns.*

This subtheme of the need for diagnostic clarity in order to meet the individual needs as presented by clients, is reiterated in the following:

*I think that many of us who specialize in this area view attachment as being on a continuum, anywhere from positive secure attachment all the way to reactive attachment disorder or attachment disorder which is the most severe form of attachment disruption and attachment difficulty and you can have children who have more mild attachment issues that maybe don't quite meet the full criteria for attachment disorder, but clearly have enough symptoms and patterns and different in that dyad or family system or in other environments, that also require treatment and intervention as well.*

Another interesting piece of diagnostic clarification is the reoccurring evidence that attachment disturbances, trauma and child development are often interrelated:

*I think that the other thing that is important to note in terms of attachment disorder, is how you view it and how you look at it in terms of what needs and how you diagnose it is that most of the children and teens we work with that have that diagnosis have had some type of early chronic trauma, there has been some research done and a real push to include in the DSM V that will be coming out, things like complex trauma or developmental trauma disorder, and I think that we do need to come up with a better formula for diagnostic criteria and that will help people, one, have uniformity in diagnosing which will also help with research because now, if we say we have a child with RAD, if you are only look at DSM IV criteria, that doesn't give you much to go with and it's such a broad range of symptoms and patterns, you can see and that is one of the*

*difficulties in the field right now. So we always have to be keeping our eyes and ears open for trauma and realize how early trauma really changes the whole attachment course um through the developmental stages....*

And again:

*Well, I just think it is professionally responsible if you are treating a child...that you should know what all of those are (RAD and Trauma) and how they might effect the child in treatment...I knew what attachment was and what a disturbance might be and certainly I can read what the diagnosis is, but really I had never come across anyone specific saying 'well this is how you should treat' that and so I began to look for ways to address that aspect of my client's diagnostic profile.*

Finally, it is important to recognize the need for future research regarding what is effective:

*I think what you are doing, what other researchers are doing, is really vital... I read a lot of research but I'm not interested in doing it. It is really important for researchers to continue their work, to find out what is working and what is not.*

Future research is also a vital part of preventing harm to clients:

*I think in the early days the thought that, there were some approaches, particularly out of evergreen Colorado, that were much more...they were militaristic. I'm not talking so much about the forced holding, where you wrap a child in a blanket, I think all along we knew that wasn't a safe thing to do, but interims of inducing rages or things like that... I don't I think that with our understanding of what's going on in the brain, I think that those approaches can be very harmful; because they are really not helping the brain to learn to regulate and settle down.*

Therapeutic techniques should incorporate the themes of theory and research, along with the subthemes of methods and diagnostic delineation, in order to prevent harm and promote safety and the creation of the secure base:

*Risk of harm with therapeutic techniques...newer brain research over last 10 years, newer studies that forced holding really can have some negative outcomes. So I do believe that the attachment community is moving away from that and there are very rare times...that you do need to contain a child for safety proposes or to have them get through....need to be careful that we are being empathic, are being attuned, not retraumatizing a child.*

Clearly, a strong therapeutic base in theory and research that integrates various therapeutic modalities and effective diagnostic delineation, are important aspects of effective therapy with children with RAD.

### **Professional Competency**

Professional competency is another key theme to effective therapy with children diagnosed with RAD. A solid grounding in theory and research is one aspect of such competency, however competency also involves the use and development of essential therapeutic characteristics. These characteristics include the following themes of emotional attunement and availability as well as healthy self-awareness.

### ***Emotional Attunement***

A therapist that is emotionally attuned and available is one that is attentive to the client in a special way through empathy, curiosity, and the ability to attend to the attachment cues and signals as presented. This emotionally attuned and available therapist facilitates the creation of a secure base between the child and primary caregiver:

*Following curiosity, reading, following empathy...and becoming aware of watching bodies and what was going on in the child and developing over the years, some skills about it are good; some capacity to really attend to what their signals were, and I guess integrate the two.*

The need for emotional attunement also integrates the awareness of the need to support, understand and empathize through recognition of the child's life story and to take caution in not over-pathologizing:

*That they are children who have been hurt and need healing that they have been deeply hurt and our job is to find ways to heal that so people would look at what the early life story is.*

An emotionally attuned therapist is also cautious of language and of over pathologizing, seeing beyond the diagnosis into the hurt and history:

*A child that has some attachment problems is the way that I would like to phrase that or who had an early tough start in life; I know that those aren't diagnostic terms. I think that it's important when I work with a family to not say that they have a RAD child because it sets a boundary...*

An emotionally attuned and available therapist is also empathetic towards the caregivers and avoids blaming as well as shaming:

*Blaming parents, they've had enough of that... I have been a parent myself and that is really a humbling experience if I of course we all want to be perfect parents but none of us are. So understanding that you can have the best intentions and still make mistakes. Umm so having empathy for the parents and making mistakes and encouraging them and their trying and the concept of being a good enough parent; all of that.*

### **Availability**

Another important characteristic of attunement is that of availability to both child and caregivers for on-going and as needed support and consultation:

*Also I do a lot of parent coaching through email because I find that one hour a week is not enough and some can't afford, or because my schedule only allows every other week, and I want to be available more than that if possible.*

This availability is important for caregiver consultation, depending on the presenting needs.

Therapeutic sessions may not allow for enough time.

*I, for instance, have a very open email policy. People are aloud to email me and I'll try to email back within the first 24 hours. I have an open phone policy... Ummm, for other therapists that might feel too loose and then I also, some people say never go over your 50 minutes, but for some sessions I'll say 'We'll go over depending on what we need' and so I just make that clear.*

### ***Self-awareness***

Another key characteristic of professional competency is that of self-awareness. Self-awareness encompasses several key subthemes including boundaries, emotional regulation, and self-care.

### ***Boundaries***

A therapist that is self-aware demonstrates an understanding of healthy boundaries and the importance of such boundaries in therapeutic healing and the creation of a secure attachment with their caregiver:

*Therapists really need to be very clear about their boundaries, their ethics, they need to know what is acceptable in terms of their license and their practice and you know if, if they are going to allow communications, what does it look like, how do you maintain boundaries.*

This is reiterated in the following:

*I have to have really good boundaries. Umm in other words, I love children obviously I'm a pediatric nurse. I've worked a lot in orphanages and that sort of thing and my gut reaction is to pick up those kids and make the world a better place for them, but what is in their best interest is to develop a secure relationship with their caregiver; so I'm constantly having to monitor myself and realize that the best way to help the child is to help the parent and the child So my own boundaries.*

### ***Emotional Regulation***

The ability of the therapist to emotionally regulate is another subtheme to professional competency and self-awareness:

*If a child erupts in a session and attacks you, you have to be able to be kind and nurturing and stabilizing and not reactive; if a parent erupts at you in session. I think the same thing applies you have to be able to see that your clients are people that are suffering tremendously and under a great deal of stress; they might not always behave well and if they don't behave well and, mum, if they don't behave well with you, that that*

*you are able to be in charge and do it in a kind way, reestablish without creating alienation or shame.*

The need for emotional regulation is also seen in the following:

*...because these kids will push your own buttons, so you have to be able to regulate and stay calm yourself.*

Skills in emotional regulation also integrates the need for emotional attunement:

*They tend to be tough kids and it's not for everyone; you have to be calm yourself, patient, in for the long haul, longer term therapy not short term; need to have those attunement and empathy skills I talked about, you have to be able to set those limits and to do it with care and concern, which sometimes is a fine line to travel, you need to be willing to think outside the box.*

The therapist's ability to self-regulate is also referred to as being "grounded". This plays a key role in the creation of an attuned therapeutic dyad, as the therapist is the holding environment for the parent and the child in order to facilitate the creation of a secure attachment:

*I have to keep myself grounded which I do with varying degrees of success because if I'm going to be the holding person for the parents who are the holding persons for the child, I had better stick around.*

### ***Self-care***

Another essential characteristic of effective therapy within professional competency is that of the therapist's ability to practice self-care:

*Ummm, becoming dysregulated myself can be harmful, so if that happens it is important that I take time to repair.*

Another clinician reflects on self-care as a means to stay regulated which in turn enables their ability to be emotionally attuned and available:

*I have to keep myself grounded; I have to keep some kind of a sense of humor. I have to find some reflection, peacetime. I've gotta nurture my spirit because if my spirit isn't nurtured I'm not going to be any good, to be that present, because no way can you do that kind of real healing for the child without it getting you in the gut because your just*

*going to stay intellectual and follow a protocol but not heal; your going to be doing things that make sense but it won't be healing.*

Self-care is different for each clinician and comes in various forms, one of which is nurturance of spirituality:

*So that piece is important to me and critical and important to nurturing and taking time for my own faith journey.*

Physical health and social health are also aspects of self-care:

*Primarily, I do meditation in my own space and belief system and spending time in meditation, reflection, reading and exercise. I exercise regularly, I'm no exercise guru, but I exercise, go to the gym, go for walks, doing some yoga, not major things, but I think that is really helpful. Daniel Siegel and mindfulness stuff really is helpful in grounding, and meditations, and mindfulness, are really helpful concepts for me and I try to keep in contact with friends and laugh.*

As demonstrated, professional competency is a key piece of an effective therapeutic process through the subthemes of emotional attunement and availability and self-awareness. These themes ensure the therapist's ability to be a holding environment for the parent and the child, within an attuned therapeutic dyad, in order to facilitate the creation of a secure attachment base.

### **Thorough assessment and evaluation**

A thorough assessment and evaluation process was also found to be key to effective therapy with children with RAD. This process involves the gathering of a detailed history through an evaluation process involving informal, formal and interactive assessments.

#### ***Detailed History***

An extensive history is gathered from a variety of sources and means but varies in style and intensity according to individual therapist and agency:



*How we do it here, and I realize that different places do it differently, but we always make sure we're getting a solid background from parental figures who know this child best, um, and we do have some biographical information forms that we ask them to fill out, and we do have specific questions that look at early trauma as well as what is more the traditional view of trauma.*

It is important that history includes information regarding development and early experiences, as well as any history of trauma:

*First of all, there needs to be a really thorough history with as much information about the early months and years of the child as possible. If a child is adopted from an orphanage, trying to become educated about the typical scenarios for that country or of that area of the country is important.*

This history assists the therapist in assessing the child's attachment history, as well as the availability of the past and primary caregivers. Assessment also includes a gathering of the caregiver's attachment history and experiences. This is again, for the purpose of assessing the parent's availability and ability to meet the child's needs. The parent-child attachment styles is critical to understanding the relationship dynamics and parenting style of the caregiver in order to facilitate change within the relationship:

*...it's important to get history of the family or of the adopted family, um, sometimes you see these mysterious issues in families where a parent is unavailable to the child because of their own substance abuse or maybe they were incarcerated or the child was very, very ill and separated from the parent in that way and then the parent comes back to the picture to raise the child. These children often have these same issues, these same attachment issues, so getting a thorough history of the family that is raising the child as well as observing their own childhood and the parenting they received is going to impact the parenting that they give... I meet with the parents first and have at least one session with them and give them quite a lot of questionnaires and testing so that I have a thorough picture. So I give them the RADQ and an attachment sort of questionnaire. Um, I give them a behavior checklist that I use and I take the AAI for both the parents and the child cuz I use DDP.*

The importance of a detailed history for both child and caregiver is reiterated in the following:

*And then I also take a really great history of the current caregivers...attachment history for themselves and their trauma history and then I might be able to discover what the parents particular sensitivities or what buttons they have that the child might push. They may have a history of domestic violence and if adopting a young boy from child*

*protective services who tends to be aggressive with her might tend cause her to become dysregulated and not function very well because it triggers her traumatic childhood... need to know equal history of the parents as the child.*

It is also important to gather information from other influences such as relatives, social workers or orphanages depending upon the child's unique circumstances:

*In terms of assessment...very extensive history of the child's experiences and some things that matter are how many caregivers have they had, how many placement experiences and when, developmentally, did all of these things happen, and any traumas that have occurred in the child's life and when developmentally did they happen. History is very important to know...child's life history and narrative of that child's life and to the best of my ability to catch it all; review documents extensively, court documents, so I have details; descriptions around events where apprehended or moved and I pay attention to the dates; anniversaries of trauma.*

Overall, history is gathered and ordered into a timeline in order to organize the child's experiences. This timeline also facilitates a corrective experience for the child when working within the attuned therapeutic dyad. A therapist may try to fill in any gaps in the child's history through their best educated guess:

*Essentially I create a life-line for the child and I place on that life line all of the risk factors that pertain to caregivers, transition, trauma and I also put in there the things that were stabilizing influences like was there always a kind grandmother, how many times they changed social workers...if the child was adopted I look at what is known about pre-adoptive history, what experiences they've had. A really, really key piece is a detailed history. If I don't have a detailed history, then I have to go with good guesses around where this child was adopted in this part of the country in this era where we know in that era the orphanage functioned in this way...we might have info about other orphanages and try to make a best guess scenario, well what was the child to caregiver ratio be, what would be the conditions. I often like to see my clients video tapes of the orphanage when they were adopting their children and ...what it looked like and what kind of care the children were getting so I have a sense of what they were experiencing...contagious crying, contagious repetitive behaviors, self-soothing, rocking behaviors...so that history is such an important piece.*

Clearly, a detailed history is critical to the assessment process in order to understand the child's life experience, which in turn is critical to an effective therapeutic process, as therapists assess the child's current functioning and develop a course for treatment.

### ***Assessment Instruments***

The use of formal and informal assessment instruments are also key elements to the assessment and evaluation process.

*We also interview the parents to find out what their experience is in terms of dealing with this child, whether they've been with this child from birth or whether this child is newer to the family, whether through foster care or adoption. We also do an interview and do some assessment instruments with the child; depends on the age of the child and depends on what we are looking for.*

Though agencies vary on the types of assessments used, common assessments may include the RADQ, CBCL, CAFAS, AAI and the PSI depending upon the child's age, history and the caregiver's stress level and attachment history.

*In terms of the individual tools that we use, um, we often use the RADQ, which parents would fill out. We do have our own attachment symptom checklist that we ask parents to fill out. We also use Daniel Hughes's Parenting Profile for Developing Attachment for parents to rate themselves in a variety of parenting areas regarding the child. Ummm, and then usually we include the behavior assessment symptoms checklist for children, currently we are using the second addition and then parents fill that out as well, but one of the reasons that we use that is we are also looking for other behavioral and emotional issues that are involved because we often see that a child with attachment not only has trauma involved, but often because of brain development that ranges with early trauma and attachment disruptions.*

Therapists and agencies may also develop specific behavior and attachment symptom checklists:

*Another questionnaire that I use is a conglomeration of questionnaires from Dr. Becker-Weidman and Terry Levy and Michael Orlans, because there were pieces of both that I like. A checklist of about 60 things, and its sorta and it's the more concerning behaviors of childhood that might be associated with attachment disorder and some of the other disruptive childhood disorders; for instance, a child with ADHD might not be controlling and bossy but children with attachment disorder are often controlling and bossy and often are charming... some diagnostic differentiation but because I'm not a psychologist, I can't diagnose...I use a sensorimotor checklist to see if I have or the parent has any concerns around the child's sensorimotor life and various sensations or sensory pathways, including vestibular and kinesthetic and so I have that checklist...and I use the CBCL and if the parents are really, really struggling with managing the child I might use the Parent Stress Index and my consultant gives me a screen so I know if there is something else I should send for on the child further...and figure out what other collaterals need to be involved for the child's mental health.*

Genograms may also be included in the assessment process:

*Daniel Hughes has developed some good parent assessment tools, so I have the parents do those as well. I have them do a very thorough genogram and the one that I developed from other models. But also it has a series of questions...based on the adult attachment interview (AAI).*

Questionnaires and assessments may also include education for the parents and insight regarding their attachment history.

*Sometimes I use the MacArthur questions (MacArthur Story Stem Battery) and have the child complete the scenario and sometimes with parents I will ask the questions that Dan Siegel talks about in his book "Parenting from the Inside Out" ... I use those questions about self-reflection so parents can assess their own attachment style. I also give parents, in the first session, the Hope for Healing book that is published from ATTACH and ask them to read that and that will usually they will come back from reading that, the first chapters in that book, and how their own history plays into it and their attachment history and that the child might have different attachment styles with different parents.*

### ***Interactive Assessments***

Interactive assessments are also used to assess the quality of the relationship, and attachment style between children and their caregivers

*I always do some kind of interactive assessment because you can get some information from the parent about a child and the interaction and you can get some information from the child about the child and the interaction but a lot of times there are pieces of the interaction that either side, or both sides, of the dyad aren't really aware of because they are so into that pattern. So the interactive assessment that we usually use is from the Marsha AC Interactive Method, which is from the Theraplay Institute. It really is a good interactive evaluation.*

Interactive assessments can also be used to assess the child's development and any emotional, social or physical pieces, such as sensorimotor issues. Interactive assessments also look for the child's attachment signals to the parents, or bodily cues, and how the parent responds:

*Ummm, and so and then of course ummm, assessment continues when I see the child and parents together I'm watching all of the nonverbals, the proximics, and it tells me more about how the child parent interact. The sensorimotor training was very valuable about*

*noticing the minutia of interactions as far as facial gestures...I'm very attuned to all of that.*

Interactive assessment can also involve art and play in order to assess the child's development alongside relational aspects:

*Typically, just do a self-portrait, draw a picture of their family and then I do, sort of routinely, that tells me a lot, from my play therapy background, about their fine motor, their attention, how the parents support them, if they don't want to do it, how do the parents help them to do that. Then I would, would, would, ahh, look at the content of their drawings, anything that would alert me...around self-esteem, self-concept...and then with the family drawing again to how is the family on the page, who is standing next to whom, how is the family relationship.*

Clearly, a thorough assessment and evaluation were key themes to effective therapy with children diagnosed with RAD. A thorough assessment involves a detailed history through the use of interviewing, questionnaires, formal assessment instruments as well as interactive and observational assessments.

### **Attuned Therapeutic Dyad**

An attuned therapeutic dyad, or the therapeutic relationship between the therapist, caregiver, and child, is another key theme found within the data that contributes to effective therapy with children diagnosed with RAD. The therapeutic dyad encompasses the theme mentioned earlier of professional competency, but emphasizes caregiver involvement and education as essential subthemes to provision of a corrective attachment experience.

### **Parental Involvement**

Involvement of the caregiver is a critical aspect to creation of a secure attachment base. Healing of a ruptured attachment relationship can only occur within the caregiver-child relationship:

*And basically the most important part of that is that I always have a parent in my office when the child is... So attachment is something that occurs in a relationship, not as an individual. I want the parent and child to be present in their relationship.*

This is reiterated in the following:

*the healing comes from the relationship with the parents and the child and not me and the child.*

Parental involvement varies in terms of process depending upon the parent's level of commitment and education. An active commitment is important to the healing process and the initial creation of an attuned, responsive and secure base:

*... the key is the parent, not the child...it is really about this parent-child commitment. Is the parent supported enough to remain committed? Is the parent confident in parenting? Ummm, and if not, what is getting in the way? And is the parent confident that and remaining hopeful that things will get better and even if they don't that there will be resources there to manage? It is really tremendous about the parent remaining open, engaged, not defensive and ummm, the parent very much so be able to regulate their own affect and their own behavior because if the parent becomes either afraid or frightened, then there will not be able to be repair, and if the parent remains in a state where they are competent, confident and committed in keeping in the fight for their child, that's really the work that needs to be done to help the parents stay in that state of being and ummm, then um everything else is the gravy on top of that and tweaking at the individual level and if we don't have those things we're in really big trouble.*

### **Parental Education**

The creation of an attuned therapeutic dyad not only involves parental involvement but also parental education:

*Yeah, if I sense that the parent is a really angry parent, then I'm going to spend a little time. Tell me a little about your story, what was your life story, your parenting, your relationship with your parents, how was security explained to you, and usually I preface a little bit about a backdrop story about what is attachment and initially, often times, it's one session, but many times it's two sessions because it takes longer to go through. So, if I have a sense that they are pretty secure people and they get it, I don't go through very much of their history. In cases where their own emotions are really high and really activated, then I'm going to spend a little more time getting to an understanding and deducing an explanation of what happened in their understanding of the concept of, 'wow what happened to me really gets carried over into how I parent. It's just automatic and*

*so how I'm going to respond is going to have to require and override feelings and I'm going to find some ways to get those baseline primitive needs met'.*

The therapist must first educate the parent on attachment and underlying theories in through literature, coaching, modeling and on-going consultation both within and outside of therapy. The type of education is dependent upon the caregiver's understanding of the child, or state of mind regarding the child. Their ability to be an attuned, safe and secure caregiver for the child lays the groundwork for the corrective attachment experience found within an attuned therapeutic dyad:

*General treatment things that I think we need to be aware of; some parents love handouts and offer them books or some good websites that really have a lot of good information that are free. Some parents really like the educational piece...some you need to do more role modeling and maybe work with them in terms of what a positive relationship is and how to be empathic.*

Caregiver education includes on-going consultation involving hands-on parenting activities that explore the parent's internal working model in order to pave the way for the parent's ability to imagine the child's feelings and reflect them back to the child for co-regulation and the purpose of enabling the child to feel understood by their caregiver. This process promotes attunement and the safety and security necessary to promote a secure attachment relationship:

*I have to attend to each child so one common thread is always giving parents that, imparting that, information to parents and sometimes parents often say that 'I need to have this repeated over and over again because it's a different way of parenting... it isn't just common sense parenting.' It is common sense parenting but it's as though they are parenting an infant, not a 7 year old, or whatever age the child is, so it requires much more intentionality and it is really the parent taking into account their own visceral awareness and becoming conscious of what they are feeling and using that to process their own feelings, the child's feelings and using that, intellectually using that knowledge, as a way that can provide some feelings for the child, um, which is why the consultation piece is really, really crucial because we need to be able to talk about this in a more heady and emotional way but also intellectually.*

The therapist uses education on trauma and attachment as a vehicle for altering their state of mind and understanding of the child's internal world. This new state of mind and empathy for the child, in relation to their attachment or early trauma, increases parental responsiveness as

they learn to recognize their child's emotions and help them to make sense of their experiences.

They become a therapeutic parent through this education:

*But parent education is so important and that's when I tell parents that they are the primary agent of change and I think with this type of situation, even more than many other mental health clinicians, the parents also need to understand how trauma and attachment has effected the child how their parenting strategies that may have worked wonderfully for traditional kids, you know kids who do not have attachment or early trauma, may not work well for this child or this teen. So in some ways we're really revamping how they're viewing their child how they're parenting and we really talk to them about they need to be a therapeutic parent so how are they going to be parenting differently. So, in some cases, that's a huge piece of the puzzle. For other cases, parents already have done some reading and they might be aware of that and some parents are much more able and willing to look at things differently.*

Once a caregiver, through the experience of an attuned therapeutic dyad, has reached a place where they have learned to be an attuned and a secure base for their child, more traditional models of therapy can be implemented. This therapeutic process provides a corrective experience for the child first with the therapist in the context of the attuned dyad, and over time in the parent-child relationship without the therapist:

*Creation of a safe base, security and stability through Theraplay. Once attachment is more secure and positive, and the child can feel safe in the office and therapeutic relationship but also with the parent, then can send some different kinds of activities home for them to practice at home, then that's when we get into more traditional models, but have to have a child that's more attached and more calm so can take it in and attempted by the child and parent together.*

Clearly, an attuned therapeutic dyad is critical to effective therapy with children diagnosed with RAD. Respondents demonstrate that caregiver involvement and education are critical to creation of this attuned dyad and creation of a secure attachment and corrective attachment experience.



## Supportive resources and collaboration

The final theme of the therapeutic process within the research findings is that of supportive resources and collaboration. Respondents refer to not only the caregiver's and child's need for support from the attuned and available therapist, but also the need for outside support and collaboration from the community.

Respondents indicate that therapists that are educated in Attachment Theory can be difficult to find. One respondent refers to the importance of making careful referrals:

*I tend to look for those people who have a lot of training, been trained in attachment. There are man people who say they are trained in attachment but then they meet with the child alone and I would say that a therapist that isn't meeting with the parent and the child isn't doing attachment work. I'm pretty well versed in people that work in attachment in our area. Because I'm registered with ATTACH, I often get phone calls from people in other parts of my state, 'Do you know of anyone in Los Angeles who works in this field?' and if I don't know of anyone I can go on the ATTACH website and help them find someone.*

Another respondent refers to the importance of collaborative work and making recommendations appropriate to the child's presenting concerns. Attachment issues are often interrelated to other issues and a holistic approach looks at the entire puzzle:

*Certainly the attachment challenged child often needs a wide array of services, particularly those who have been prenatally exposed.*

And:

*There are other concurrent mental health diagnoses that we have to be aware of in terms of making recommendations and being involved in providing appropriate and effective treatment, so we are not just looking at trauma and attachment but also that we're looking at other pieces of the puzzle.*

Therapeutic support and collaboration is important not only for caregivers and child, but also for family members or friends involved with the child. In session work, as well as referrals, are an important part of providing this support:

*We also model support and do as needed, just see parents alone without the kids, because they sometimes really do need that support. It is difficult, we try to have them look within their own system of family friends, you know and see who might be willing to help out. We're certainly willing to have them bring family members and friends in and try to give them more information so they can understand what the parents need and what they're going through and what's going on with their children. Anytime we find a service people are using in our community... we know who each other are and we know which groups are better at understanding trauma and attachment and we find a support group we know is good. We are making referrals.*

Support groups can provide a key piece that therapists may not be able to provide within the therapeutic dyad.

*I think the parents can learn from each other and they can see some things in each other. We do have an organization that is doing a parent support group and is also doing kind of a sort of social skills group for children and umm I'll refer to that. They are also doing a class called 'You, Me and God', a two hour Sunday school class... but there is also a developmental specialist there that understands attachment and can deal with the acting out behavior and a therapist so, so they are really trying to help the whole child and they also talk about some of the behavioral issues that come up. So those are some wonderful resources in that area.*

Sometimes parents may need outside therapy, as well as an outside support group:

*Some parents, I have worked with some families, the parents can't get past, can't get past, the rigidity that 'the kid is trying to make my life miserable and they are doing this to make my life miserable' and can't get to a place where they are trying to understand where it is coming from, the empathy, and that really is hard. Sometimes we need to stop the therapy and encourage the parents do their own work with their own attachment history. Ummm so, and this is where a parent support group can be really helpful because often parents will be hearing these things from other parents about the work they had to do on themselves and it doesn't feel like a therapist's blame anymore. When a therapist suggests, then it feels like it is one more person blaming, but if they can hear from other parents, in their parenting of their child, sometimes it feels like its not a blaming kind of thing.*

Support groups were also seen as an important therapeutic piece for both parents of adolescents and adolescents themselves:

*My support group, we have parents who have teenagers dealing with kids in adolescence, and it's much more effective with teenagers.*

Trainings can also be a useful means of community collaboration:

*...as far as other services that are essential. First of all I do a lot of training for social services and for foster parents and the organization. I do this support group with parents and I provide a lot of trainings*

Other important community collaboration may include a work with a variety outside professionals:

*You've probably heard that many of these children have sensory integration issues and have been prenatally exposed, so I have some occupational therapists. As well as I love to read and use and loan out books parents are interested in reading about it themselves. So I refer to occupational therapy... many times there are educational special needs so I will meet with the principal, the educational staff at school, umm and try to help them understand or write a letter for an IEP. Let's see, what other services. Sometimes children need a good thorough psych evaluation by a specialist, a psychologist. A lot of this depends on the family's resources, but these are the ideal situations. It would be great if every child had a neuropsych evaluation.*

Another respondent refers to the importance of Neurofeedback Therapy or support groups for adopted children. However, also refers to the financial obstacles often present to securing such services:

*Neurofeedback can be very helpful again that's a financial issue for a lot of families ummm and then One of my colleagues who lives about an hour away is doing some group work with adopted kids, and its exciting hearing about it. I think it would be a wonderful thing to try to figure out time wise how to do that (laugh). But I think that can be extremely helpful for looking at a group of children who have all been adopted who are all dealing with some of these same issues.*

Community collaboration also is lacking in services for families. Appropriate respite care, family based therapists and teams, and trained and affordable professionals are severely lacking within the attachment community:

*There's not appropriate respite for kids that have this level of difficulty or for people to understand how respite is important. Can't buy into the superficially engaging parts of these children and they have to be sure to keep appropriate boundaries. Some things are for parents only... Family based therapists, teams that go into the family, but professionals have training on early attachment and trauma. To me, that's where we*

*have such a dearth of appropriate services for kids and families so I guess that's an important piece...not enough services, funding or money for family to be able to get the services that they need.*

Clearly, community collaboration is a common theme throughout the findings and a critical piece to therapeutic success with children diagnosed with RAD.

The findings clearly demonstrate the importance of the reoccurring themes of theory and research, competent professionalism, thorough assessment and evaluation, an attuned therapeutic dyad, and community collaboration in the provision of effective therapy. Some themes consisted of subthemes that contributed therapeutic success.

### **Discussion**

The research examined the experiences of mental health practitioners in regards to their perception of what is effective in therapy with children diagnosed with RAD. The specific objective was to study essential elements that contributed to increased attachment bonds between the child and caregiver, as well as elements that led to decreased RAD symptoms.

Attachment Theory is a critical underlying component in both the findings as well as the literature, and was the overall conceptual framework from which this study was organized and designed. The overarching goal of the therapeutic processes, under Attachment Theory, is to improve parental responsiveness and attunement, assist the child in the achievement of appropriate developmental tasks, and develop a safe and secure attachment base (O'Connor & Zeahna, 2003). This secure attachment provides a corrective experience leading to the child's development of a functional internal working model (Perry, 2001; Slade, 2005). The findings and literature demonstrate an overall therapeutic base of Attachment Theory with overlapping themes that are seen as critical to the therapeutic process and successful outcomes.

The key themes found within the findings were those of theory and research, professional competency, assessment and evaluation, attuned therapeutic dyad, and community collaboration. The critical components found within the literature were those of assessment and evaluation, education, attuned therapeutic dyad and corrective experience. Themes within the literature were complementary to the themes within the findings, namely those of assessment and evaluation, education and attuned therapeutic dyad. Although corrective experience appears to be an outlier to the findings, it is in fact interwoven throughout the findings, particularly within the themes of theory and research, professional competency, therapeutic dyad and community collaboration. In fact, the overall purpose of the therapeutic process found within the findings is to provide a corrective experience for the child and caregiver within an attuned therapeutic dyad (Boris & Zeanah, 2005). The theme of community collaboration also appears to be an outlier to the literature. Though support within the therapeutic dyad was seen within the literature, the emphasis on outside community resources, beyond the dyad, is unique to the findings. The findings also emphasized specific characteristics and qualities of therapists that contribute to therapeutic success. These specific qualities are addressed in the literature description of DDP in “PLACE”, however not to the same degree as in the findings (Becker-Weidman, 2006; Slade, 2005). Overall, the themes found within the findings and literature were overlapping and complementary.

Clearly, the findings and the literature overlap in conceptual framework, as well as in complementary themes. The framework and themes all work together within the therapeutic process and holding environment in order to provide a safe, stable, emotionally attuned, and reflective caregiver. This corrective attachment experience enables a restructuring of the child’s dysfunctional internal working model, which leads to increased attachment bonds, as well as a

decrease in RAD symptoms (Boris & Zeanah, 2005).

Several methodological limitations should be discussed and considered before consideration of this study's results. First, the results of this study cannot be generalized to all children with RAD, as the sample size was non-random and limited in size, scope and demographics. Second, the participants consisted of professionals with a wide variety of experiences, education and training, yet they were also all registered members with the ATTACH organization. Therefore, they are not representative of all mental health practitioners, let alone those that work with children with RAD. Third, the findings may be skewed as a result of the bias of the researcher and their contribution to the design of the study, interview questions, and derived themes. Nevertheless, the strengths of this study, alongside the limited resources and scope of the project, compensate for the weaknesses of the design.

Future research ought to be dedicated to more in-depth study of the above core themes within the framework of Attachment Theory. The themes noted are important to recognize, but remain broad and are in need of further refinement. Specific therapeutic methods and modalities were not explored in depth, such as DDP or Theraplay, though they were referred to throughout the findings. Future research ought to include comparative studies involving a wide range of therapist perspectives and modalities, including those models that are not inclusive of Attachment Theory. Longitudinal studies exploring the perspective of mental health professionals, but also caregivers, adolescents and adults diagnosed with RAD or attachment disturbances, would also be beneficial to furthering our understanding of effective therapy. Finally, future research should focus on gathering data regarding societal views and stigmas on RAD and attachment and work to dispel myths or misconceptions regarding these children and their families.

The findings present many implications for social work practice and future research. Mental health professionals ought to recognize the importance of continuing research and practice with children diagnosed with RAD and implications of poor training and education in treatment of RAD. Mental health professionals should be aware that the understanding of RAD and attachment is progressive and quickly changing as new research emerges in neurology and brain development. Not only is the attachment experience critical to healthy child development, it is also essential to a healing therapeutic process. Mental health professionals that are not educated in these areas may cause serious harm. Mental health professionals that are educated in these areas, as well as the core themes of the findings, have the ability to empower caregivers through the provision of healing opportunities, that might be difficult to both access and afford.

### **Conclusion**

In conclusion, it is clear that effective therapy with children with RAD is a complex issue, especially in regards to diagnosis and access to empirical studies. The intent of this research was not to promote Attachment Theory, or any particular treatment modality. Rather, the intent was to add to existing literature and promote further research in effective treatment practices that minimize harm. Empirically based research is non-existent and literature ranges in perspective regarding effective treatment approaches. This leaves caregivers and mental health professionals wanting in their access to effective treatment for children with RAD. The overall hope of this research is to strengthen current treatment practices, competency of caregivers and professionals, as well as to contribute to further discussion and research regarding the future of effective therapy with children diagnosed with RAD.

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### **Appendix A: Interview Questions**

1. Tell about your education, experience and current level of practice in regards to working with children with RAD and their families?
2. Describe your understanding of attachment disorder and the course, prevalence and manifestation of symptoms and behaviors?
3. What key factors would you say are essential to the effective assessment and treatment process for children with RAD and their families? Why?
4. What specific therapeutic activities and techniques have you found to be especially successful in improving the overall mental health of children with RAD and their families? Why?
5. What qualities would you say are essential for a therapist that works with children with RAD and why?
6. What kinds of services are essential to the overall mental health of families with a child with RAD?
7. What kind of education and training would you consider essential to a therapist that works with children with RAD and their families?
8. What do you wish professionals knew about children with RAD that you believe would lead to better treatment outcomes?
9. In your experience, are there therapeutic techniques that you have found to pose risk of harm to children with RAD and their families?
10. What kind of future research do you think would be beneficial to children with RAD and their families?

## **Appendix B: Research Information and Consent Form**

### **Effective Therapeutic Techniques with Children Diagnosed with Reactive Attachment Disorder**

**IRB # 295624-1**

You are invited to participate in a study investigating effective therapy with children diagnosed with Reactive Attachment Disorder (RAD). This study is being conducted by Jennifer Lawrence, LSW, student in the Masters of Social Work program at the University of St. Thomas (UST) and St. Catherine University (SCU) of St. Paul, MN. Supervision is being provided by Dr. Felicia Sy Ph.D., (Chair); Pamela Baker, MS, LISW, LMFT and Paul Buckley, LMFT.

You were selected as a possible participant from the referral of professionals and agencies familiar with your knowledge and experience in working with children diagnosed with RAD or attachment disorders. This study is an opportunity to demonstrate my ability to design and implement a graduate level qualitative research project. The overall purpose is to increase and contribute to the knowledge base concerning effective therapy with children diagnosed with RAD.

#### **Procedures:**

If you choose to participate, you will be asked to partake in an audio-taped, qualitative semi-structured interview regarding the following research question: “What are effective practice based therapeutic strategies for children diagnosed with RAD and their families from the perspective of mental health professionals?”

The first and only interview will be approximately 45 minutes to 1 hour in length and may be conducted in person, over the telephone, or via Skype. The interview will be transcribed and data will be coded and analyzed. Results and findings will be published and presented publicly at St. Catherine University and University of St. Thomas in St. Paul, MN.

#### **Risks and Benefits:**

The study has minimal risks and minimal benefits. Working with children with RAD can be emotionally and psychologically taxing and discussing the nature of such experiences may cause emotional or psychological discomforts. The likelihood of such distress is minimal. Subjects may reasonably expect minimal inconveniences such as taking the time, energy and resources needed to both schedule and participate in an interview. In order to minimize inconveniences, the study may be conducted at the site of the interviewee, over the telephone or via Skype at a time convenient for the participant. Confidentiality will be ensured through the interviewer’s prior reservation of a private space that limits interferences and interruptions. If significant emotional or psychological distress occurs during the interview, the interview will be terminated immediately followed by the opportunity to debrief. There are no direct benefits to participation in this study, however an indirect benefit will be the increased knowledge base regarding effective practice based techniques that are effective with children with RAD.

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. The transcriptionist will have access to the audiotape following the omission of all identifying information. The research results will be kept on a password protected computer and locked file cabinet in the researcher's personal office. Following the data analysis and writing of the final report, all original reports, audiotapes and identifying information will be destroyed by 7/31/12.

**Voluntary nature of the study:**

Your participation in this study is entirely voluntary. You may skip questions and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University and the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time and data will not be used and will be destroyed.

**Contacts and questions:**

If you have any questions, please feel free to contact me, Jennifer Lawrence, at 651-307-1447. If you have additional questions in the future, you may contact the University of St. Thomas Institutional Review Board at 651-962-5801. You may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

**Statement of Consent:**

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

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I consent to participate in the study and I agree to be audiotaped

---

Signature of Participant

Date

---

Signature of Researcher

Date

## Appendix C: Participant Recruitment Flyer

# a **RAD** study

Taking a **Closer** look

## A STUDY ON EFFECTIVE TREATMENT FOR CHILDREN DIAGNOSED WITH REACTIVE ATTACHMENT DISORDER (RAD)

The goal of this study is to explore effective treatment strategies for children diagnosed with Reactive Attachment Disorder (RAD) from the perspective of Mental Health Professionals

- ⇒ Participants will complete one audiotaped interview lasting approximately 1 hour
- ⇒ The interview will include questions asking about your perspective on effective treatment of children diagnosed with RAD
- ⇒ This study can be done either in-person, by telephone, or via Skype

You may be able to participate in this study if you ...

- ⇒ Are a licensed clinical professional with at least 5 years experience working with children with complex trauma or attachment disorders

**For more information, contact:**

Jennifer Lawrence, Study Coordinator Phone 651-307-1447 or Email  
lawr6056@stthomas.edu

## Appendix D: Recruitment Telephone Script

### Telephone Script

P = Potential Participant; I = Interviewer

I - May I please speak to [name of potential participant]?

P - Hello, [name of potential participant] speaking. How may I help you?

I My name is Jennifer Lawrence and I am a Masters student in the School of Social Work at the University of St Thomas and St. Catherine University of St. Paul, MN. I am currently conducting research on effective treatment strategies for children diagnosed with Reactive Attachment Disorder. As part of my research, I am conducting interviews with mental health professionals to discover their perspectives on effective treatment for children diagnosed with Reactive Attachment Disorder.

I received your name and credentials from a list of clinical professionals published through the Association for Treatment and Training in the Attachment of Children's (Attach) website or Minnesota Adoption Resource Network (MARN) website. I understand that you are a licensed clinician with experience in working with children who have experienced complex trauma and have received training as well as supervision in attachment, trauma or other comparable areas. I would like to speak with you about your perspectives on Reactive Attachment Disorder and disorders of attachment as well as your perspective on effective treatments for children with Reactive Attachment Disorder. Is this a convenient time to ask you a few questions and provide you with further information about the study and interview process?

P No, could you call back later (agree on a more convenient time to call person back).

OR

P Yes

I I would like to verify that you meet the expectations required for this particular study. Would you consider yourself a licensed clinician with significant experience working with children with trauma and/or attachment disturbances? Do you have experience working with children with Reactive Attachment Disorder and their families? Would you consider yourself to be a good candidate for this study? Why or why not?

I Read informed consent followed by: With your permission, I would like to email/mail/fax you an information letter which has all of these details along with contact names and numbers on it to help assist you in making a decision about your participation in this study.

P No thank you. OR P Sure (confirm address/fax number).

I Thank you very much for your time. May I call you in 2 or 3 days to see if you are interested in being interviewed? Once again, if you have any questions or concerns please do not hesitate to contact me on my confidential cell phone at 651-307-1447.

P Good-bye. I Good-bye.

**Appendix E: Recruitment E-mail**

Dear (Potential Participant),

My name is Jennifer Lawrence and I am a Masters student in the School of Social Work at the University of St Thomas and St. Catherine University of St. Paul, MN. I am currently conducting research under the supervision of Dr. Felicia Sy. I am conducting interviews with mental health professionals to discover their perspectives on effective treatment for children diagnosed with Reactive Attachment Disorder.

I received your name and credentials from a list of clinical professionals published through the Association for Treatment and Training in the Attachment of Children's (ATTACH) website (or) Minnesota Adoption Resource Network (MARN). I understand that you are a licensed clinician with experience in working with children with attachment disorders. I would like to speak with you about your perspective on Reactive Attachment Disorder and disorders of attachment as well as your perspective on effective treatments for children with Reactive Attachment Disorder.

With your permission, I would like to call you in 2-3 days to see if you are interested in being interviewed. If you have questions or concerns, please do not hesitate to contact me on my confidential cell phone at 651-307-1447.

Thank you for your consideration,

Jennifer Lawrence, LSW

Graduate Student at the School of Social Work

University of St. Thomas and St. Catherine University