COMMUNITY PSYCHIATRIC CENTERS

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THE "ANSWERS" SERIES

ATTACHMENT DISORDERS

The following answers are from excerpts of the writings of Dr. Lowenstein, M.D., Dr. Carosso, Psy.D., latest research findings, and the DSM-IV

What is Reactive Attachment Disorder?

Attachment Disorder is a condition in which individuals have difficulty forming loving, lasting, and intimate relationships, The words "attachment" and "bonding" are often used interchangeably. The disorder varies in severity, buto Reactive Attachment Disorder (RAD) is usually reserved for those who demonstrate a significant lack of ability to be genuinely affectionate with others.

Individuals with RAD usually fail to develop a functional conscience and did not learn how to trust.

What causes RAD?

Any number of situations, early in the child's life, can contribute to symptoms of RAD. The critical period seems to be from conception to two years of age, but trauma and neglect at anytime in early childhood can produce some signs. Causes include:

- Maternal ambivalence
- Sudden separations from primary caregiver
- Abuse
- Frequent moves or placements
- Traumatic pre-natal experiences such as inutero exposure to drugs/alcohol
- Genetic Predisposition
- Birth trauma
- Undiagnosed painful and chronic illness
- Inconsistent or inadequate daycare
- Unprepared mothers

Why is early childhood so important. I thought we forget most of what we experienced as children?

We may forget on a conscious level, but what happens to us during early childhood has a profound and significant effect on the rest of our lives. For example, we learn 50% of what we need to know in the first year of life. 25% more is learned the second year and thereafter, only 25%more survival skills are added. If we learn, during this critical time, that primary caregivers are abusive, neglectful, inconsistent, capricious, and aloof, this can influence our perception of others, the world, and ourselves, for our entire life.

What are signs of an infant at-risk?

- Weak crying response
- Tactile defensiveness
- Poor clinging or resistance to cuddling
- Poor sucking response
- Poor eye contact
- No reciprocal smile
- Indifferent to others and situations
- Failure to respond to mother and father
- Delayed developmental milestones
- Flaccid

Do I need to obtain an evaluation? If so, by who?

It is vital to have an assessment conducted by a Board Certified Child Psychiatrist or Licensed Psychologist. In the event of a diagnosis or that there are signs of Attachment Dysfunction, there are a number of treatment options.

What are some of the signs of RAD in older children?

Compulsive need to control others, including caregivers, teachers, and other children.

Intense lying, even when caught in the act.

Poor response to discipline: aggressive, oppositional, or defiant.

Lack of comfort with eye contact (except when lying).

Physical contact: wanting too much or too little.

Interactions lack mutual enjoyment and spontaneity.

Body functioning disturbances (eating, sleeping, urinating, defecating).

Increased attachment produces discomfort and resistance.

Indiscriminately friendly, charming; easily replaced relationships.

Poor communication: many nonsense questions and chatter.

Difficulty learning cause/effect, poor planning and/or problem solving.

Lack of empathy; little evidence of guilt and remorse for others.

Ability to see only the extremes; all good or all bad.

Social withdrawal or over intrusiveness.

Extreme difficulty reestablishing a bond following conflict.

TREATMENTS AND STRATEGIES FOR CHILDREN WITH R.A.D.

I've heard a lot about eye contact and being "attuned" to the child. Please explain more about this.

It is Important to establish and sustain eye contact whenever possible. All conversations, especially positive interactions, should include ample eye contact (eye contact = attachment). Also, at the same time, "mirror" the affect and/or mood of the child. For example, smile when the child is smiling and show sadness or disappointment when child speaks of something troubling him or her. "Mirroring" in this regard shows the child that you are "attuned" or connected with the child's feelings and thoughts, which significantly helps to facilitate attachment and bonding. A further example would include providing eye contact and smiling as the child explains that he got an A in school that day; or

showing concern in your facial expression, and eye contact, as child explains how he had trouble on a test. At the same time, a reflective and empathic comment would be helpful such as, "that must have made you feel sad when you didn't do so well on the test or "looks like you're happy for earning that A… you worked hard…"

Can I expect a difference in how my child reacts to me, as opposed to his teacher?

Keep in mind that your child may function well with secondary and tertiary figures in their life (extended relatives, teachers…) but have difficulty with primary attachment figures such as their adoptive parent. In that regard, closer attachments can be anxiety-provoking for children who have histories of trauma.

Sometimes I yell at my child who has been diagnosed with RAD, is this okay?

Remain calm and emotionally in control when dealing with behavioral issues of children who have experienced trauma. Stress for a vulnerable child, with a history of trauma (especially repeated trauma), leads to mental confusion and short-term memory lapses; consequently, confronting in a harsh manner, with threats and punishments, only worsens the child's problem-solving abilities and worsens acting-out. Remember, stress can cause the child to regress back to age when trauma took place. Before dealing with the problem, calm yourself (take three deep breaths, breathing deeply, in through your nose, out through your mouth, then approach child in a calm and supportive manner). Use *reflective listening* techniques to emphasize that you understand the level of *fear* that underlies the misbehavior. Remember, for a traumatized child, misbehavior is often a *signal* of underlying, unresolved fear. Misbehavior does not necessarily denote a child wanting negative attention but, rather, that they *need* attention. Time-out tends to be counterproductive; what is needed is "time-in" (spending extra time with the child). Try to see the child's behavior not as manipulative but, rather, as fear-based and subconscious, which will help to reduce your frustration. Get on child's level (kneel down if you have to), make eye contact, and especially control nonverbal cues such as tone of voice, facial expression, posture, and gestures to avoid presenting as threatening or intimidating. Many children were traumatized at a pre-verbal age such that the nonverbal is more important than verbal ("it's not what you say, but how you say it").

In the event of "losing your cool" and being harsh or emotional, shortly thereafter (once you've taken the three breaths and calmed down) repair the interaction with a hug and comfort. Anger is destructive and the "separation" from the angry parent is sometimes seen as intolerable and can worsen the misbehavior.

It is often best to deal with problem behaviors as a sign of child's fear. Please contact this psychologist for specifics but interventions, for traumatized child, should typically be based in empathy, rather than punishment. Consequently,

try to ignore the behavior (lying, stealing trivial items…) and attend to the child through "time-in" that may include something as simple as sitting quietly next to child or reflecting that you're looking forward to when child can feel comfortable telling the truth. Avoid being confrontational, judgmental, argumentative, or accusing. Interventions for traumatized children tend to be rather simple, but not easy due to our long-standing impulse to implement some type of punishment for fear that, if we don't, the behavior will worsen or we will be reinforcing misbehavior. "Time-in" may be seen by some as reinforcing, but it's prcisely what the child needs. Please contact Dr. Carosso or Dr. Lowenstein for further insights regarding specific problem behaviors.

My child does not seem to know how to respond appropriately sometimes. What should I do?

Give the child the correct or appropriate words to bond and problem-solve. Provide a cue such as "Johnny, say 'Mom, I need your help…'

My child seems to know what to do, but when the time comes, does not do it?

There is a difference between knowing and doing. A child may "know" what to do, but struggle with carrying out the behavior. It may be necessary to "walk" the child through the activity or endeavor. When dealing with your child, especially during times of difficulty, consider the child's developmental or emotional age as opposed to the chronological age. In that regard, expectations would be considerably different for a three year-old (emotional age) compared to a 13 year old (chronological age).

What is a way to motivate positive behavior?

Utilize "pizzazz" that entails an animated response to good behavior including wide-eyed wonder, excited tone of voice, shocked disbelief, exaggerated body gesture, and gleeful response. To be used when child is demonstrating respectful and responsible behavior, being fun to be around, completing chores, and making any change from anti-social to pro-social behavior. This helps your child to associate specific behaviors with "having fun" and "being fun" to be around.

I imagine that spending both quality and quantity time with my child is important?

Caregivers need to spend 30-45 minutes of daily quality time with child (not including watching television). National average is between 10-13 minutes. This would need to include activities that involve eye contact and close interactions. Vital to strengthen the relationship and build the bond.

Sometimes I feel so stressed. Does that get in the way of parenting?

It is vital for caregivers to decrease their level of stress. A parent who is stressed-out will have trouble bonding

with child just as a traumatized child has difficulty attaching to the parent and family. Stress leads to emotional dysregulation, which contributes to emotional withdrawal and detachment. Take time for yourself, get a babysitter at times, go on vacation (without RAD child), exercise, eat right, and use family and community resources such as wraparound services.

Sometimes when I get mad, I threaten to have Jimmy live somewhere else. Is that a problem?

Caregivers should never threaten a child's placement, or at least not in front of child. This issue can be discussed, as needed, with professionals but not in front of child and never as a means of punishment.

My child sometimes plays with toys much younger than what I would expect. Is that normal?

Consistent with the tendency to "regress when stressed," take note of the toys to which the child is drawn especially when they are having a rough time. Usually the child will play with sensory as opposed to abstract (symbolic) toys. Make those types of toys available, as needed. Usually toys from 0-3 years of age. Moroever, play for these children is often destructive; teach them, in a patient and sensitive manner, to play in a constructive manner. Model building, functioning, and productive play as opposed to haphazard and destructive play that involves only "taking things apart."

I've heard that it's important to stimulate all the child's senses, in a positive way, to promote bonding. Is that true and how do I do it?

It is important to help child feel as "fear-free" and open to others as possible. The more uncomfortable and fearful they feel, the more closed-off they will be from interacting with others in a positive and pro-social way. In that regard, it can be helpful to develop a "sensory map" in terms of discovering what your child finds pleasurable for each of the senses (olfactory, tactile, visual, auditory). Then, provide lots of pleasurable stimuli over the course of day. This could include purchasing certain fabrics for clothes, painting bedroom a particular color, using various scents, calming music, and various recipes. Sweets, namely chocolate, can be quite effective but need to be used judiciously. However, if sweets are used, do so during the quality time with parent (to increase positive associations between good feelings and parent).

My child, who has been diagnosed with RAD, has no understanding of planning for the future or predicting consequences. What can I do about that?

The concepts of "object constancy" and "object permanency", deal with being able to imagine something that is not currently available to our senses (imagine a ball that cannot be seen). These abilities are developed during childhood but are deficient if the child is neglected or abused. These abilities help a child to

plan ahead, work toward goals, effectively problem-solve, and attach to others. If lacking, this can also contribute to separation anxieties, fears, and subsequent misbehavior. Object Constancy and Permanency can be bolstered, for example, by playing "hide and go seek" on a regular basis. This can involve actually hiding (and the child hiding, taking turns) or a personal object being hidden. This is helpful to heal developmental delays and, with creativity and various twists, can be made to be fun. It is also vital to be consistent, have only one primary caretaker for the child (one person who takes care of most of the child's needs and is available throughout the day) and be as unemotional as possible when faced with misbehavior and animated when sharing "good times" with your child. In the meantime, it will be necessary to provide direction in a highly concrete, simple, specific, and direct manner. Multi-step directions are usually met with frustration.

Help your child develop cause-effect by learning sequential steps for achieving goals as opposed to using "magical thinking". For example, to make the football team will require practicing daily, learning the plays, being a team-member…

Tell me about 'transitional objects.'

Transitional objects (comforting items that remind child of safety, warmth, and love) during times of separation (e.g. school, bedtime) are often helpful and can include audiotape recordings of the foster or adoptive parent's voice at bedtime. For example, utilize places such as Kinko's and have a blown-up picture of the child and parent hugging imprinted on the child's pillowcase and sheet, which helps to increase feelings of "safety, warmth, and comfort" during vulnerable times such as bedtime. Pictures of this sort can be placed on key chains, lockets... Use all the senses. Some children are comforted by taking a piece of cloth to school with adoptive parents perfume sprayed on it or wearing an undershirt worn by guardian the night before. Telephone call to parent or audio tape (of parent's voice) during the day while at school can also be helpful.

My child seems to refuse to have fun with the family. What can I do?

There is a tendency for RAD children to sabotage family fun but parent can remain in control of nurturing hugs, smiles, and encouraging attention and affection. Adults need to be role model of what "being fun to be around" means. When frustrated, take a few deep breaths, remember where the misbehavior originates (child's fear based in early trauma), and use "time-in" (spending quality time with child) to work thru the issue.

What is 'power-sitting' and 'lap-time'?

Power-sitting can be helpful to increase self-control and for self-soothing. Used to help child re-group during times of transition. Not punishment or time-out. Should be on floor and near blank wall. Provide mat or carpet. Child should maintain good posture (sit straight, legs folded, hands on knees, head straight)

but do not punish for poor posture but use Pizzazz (see above) for good posture. Please contact this psychologist for more information in this regard.

Lap-time can be helpful to increase feelings of attachment and bonding. It involves child sitting on parents lap and helps in many respects including teaching the child how to receive appropriate touch from, for example, adoptive parent. Parent/Guardian controls time and place but, obviously, open to child-request Try to maintain eye contact. A pillow between child and parent can be used for sexually reactive child. If child refuses, then need to begin with less intrusive touching that can include simply sitting near the child.

What should I focus on in terms of social skill development?

Skills that will need to be emphasized include (Attwood & Gray) Entry: how to join-in with a group of children and how to welcome a child who wants to join-in; Assistance: recognizing when and how to provide and accept help from others; Compliments: providing compliments at appropriate times and knowing how to respond to a friend's compliment; Criticism: knowing when criticism is appropriate and inappropriate, how it is given and the ability to tolerate criticism; Accepting Suggestions: incorporating the ideas of others in the activity; Reciprocity and Sharing: a "back and forth" sharing of conversation and resources (toys…); Conflict Resolution: working through disagreements with compromise, accepting opinion of others; Monitoring and Listening: learning to observe peer's body language and monitor their contribution to the activity. Monitor one's own body language to reflect interest in peer and activity; Empathy: recognizing when appropriate comments and actions are required in response to peer's circumstances and the feelings of others; Avoiding and Ending: teach the appropriate comments and behavior to maintain, end, or avoid an interaction.

Also emphasize the potential benefits of associating with peers who a good influence as opposed to those who are not. Encourage opportunities for involvement with such peers and reinforce that choices in that regard can result in increased privileges.

Use social stories, role playing, and rehearsal of social situations.

Utilization of feedback, i.e. videotape or audio recording may also be helpful.

Introduce child to peers, or structure social opportunities, with peers who have similar interests.

Explain why a particular behavior is necessary; don't assume an understanding of the reasoning behind the pro-social behavior.

I learn better by being shown something and then doing it myself, as opposed to only having something being explained to me. Is that typical? Is that also true for my child?

Yes, that is a great point. It is important for professionals, when teaching problem-

solving and task completion, to rely on "experiential" approaches (literally walking the child through the activity) as opposed to explaining and using only "words." The same is true for teaching parents new strategies; rely on actual "hands-on" and experiential strategies as opposed to only teaching in a didactic manner.

Helpful Resources that can be found at local C.P.C. office library:

Attachment and Bonding

- Building the Bonds of Attachment (Hughes)
- Touchpoints (Brazelton)
- When Love is Not Enough (Thomas)
- Community Psychiatric Centers has available a number of helpful videos by Nancy Thomas including "Give Me A Break: Help for Exhausted Parents of Difficult Children" and "Captive in the Classroom"

Information about medication

- Straight Talk About Psychiatric Medications For Kids (Wilens)
- Medications for School-Age Children: Effects on Learning and Behavior (Brown and Sawyer)

Sleep problems

- Solve your Child's Sleep Problems (Ferber)
- Potty Training Individuals on the Autistic Spectrum (Steven, J)