## Reactive Attachment Disorder (RAD)

**RAD** is an inappropriate ability to relate to peers and adults in most settings.

*Children with RAD were unable to attach to a primary caregiver in their early life and this negatively impacts on their relationships.*

RAD begins before age 5 and relates to the bonding process in the 1st 2 years of life.

RAD is not solely explained by a developmental delay or pervasive developmental disorder (PDD).

The problems may continue as the child grows older.

The causes of RAD are not known. Most children with RAD had severe problems in their early years – physical or emotional abuse or neglect, inadequate care in an out-of-home placement, multiple or traumatic losses or changes in their primary caregiver.

There are 2 types of RAD: inhibited (failure to initiate or respond socially) and disinhibited (excessive familiarity with strangers).

RAD is common in foster and adopted children, but also occurs in children where, at an early age, there was a divorce, illness or death.

A student with RAD manipulates to control a world he/she considers unsafe and even fatal. The battle for control is constant.

The separation process in children has 3 stages: initial protests (crying, screaming, etc.), depression (withdrawal), and anger or detachment.

Students with RAD will not outgrow it, and treatment is critical.

According to Nancy Thomas (see Resource section), students with RAD talk for 3 reasons: to interrupt, to make noise, and to control.

A student with RAD is reinforced when adults “lose it”.

Adolescents with RAD are often part of the juvenile justice system.

Students with RAD may make false accusations of abuse against parents, school staff, or other caregivers. They may pretend to be fearful of their parents to reinforce the false allegations.

Students with RAD often try to triangulate (separate; play one off the other) parents and school personnel. Good communication with the parents is critical.

Set up an alternative communication system with the parents (e.g., phone, e-mail, written information sent to work address or a relative’s home) – the student may destroy notes or fail to bring papers home.

Behavior usually gets worse before it gets better – support the parents and work with the mental health team. If school is “on hold” while other therapy issues are addressed, try to at least maintain the status quo and not make the problems worse.

Timeouts do not work with students with RAD – they want to be isolated.

The most important thing is to create a safe environment for the student with RAD.
Symptoms

- Lack of guilt or remorse
- Blames others; doesn’t accept responsibility for own actions
- Has difficulty with cause-and-effect
- Views the world as unsafe and untrustworthy
- Begins before age 5 and occur
- Factors that put a child at high risk are sudden separation from the primary caretaker, frequent moves and placements, prenatal exposure to alcohol/other drugs, unprepared parents with poor parenting skills
- Poor eye contact unless the student is lying (in which case they usually make good eye contact)
- Stealing, chronic lying
- Sexual acting out
- Bossy
- Often gives “stiff” hugs; child is not “cuddly”
- Manipulative
- Difficulty understanding how their behavior affects others; lack of empathy
- Poor impulse control
- Physical aggression, injuring animals or other people; usually a lack of remorse afterward
- When stressed, child may bang his/her head; scratch, bite or cut himself/herself; rock back and forth
- Overly friendly to strangers, but unable to be affectionate with those close to him/her
- Mood swings
- Regressive behaviors (babytalk, noisemaking, animal noises, etc.)
- Temper tantrums
- Refuses to do assignments or does them poorly
- May “jabber” and speak nonsensically, slur words, mumble
- Acts superficial and phony
- Abnormal eating – either gorging or starving
- Generally has no friends – considered too controlling or bossy by other children
- Fascinated by gore, evil, destruction, etc.
- Often prefers to be alone; does not do well in groups
Possible School Interventions

- Conduct an FBA to identify triggers and design appropriate consequences for misbehavior. Triggers may not be apparent with the student with RAD, and may require some digging.
- Keep a predictable schedule and routine; be predictable so that the student gets the message that you are trustworthy.
- Teach social skills by modeling; explain “why” certain behaviors are desireable/undesireable.
- Avoid power struggles – be matter of fact; choose your battles.
- Teach relaxation and stress reduction.
- Make information relevant and meaningful to the child – they are focused on being safe, so will typically not engage in learning unless they see it as relevant to their immediate needs or long-term survival.
- Try to avoid group activities, as this may increase the child’s anxiety and need to control.
- Students with RAD usually need immediate feedback and gratification. They have difficulty dealing with delayed consequences.
- Keep in mind that regardless of the number of times you have helped the student, tomorrow you can be the enemy and the student will not recall your helpfulness.
- Allow choices – reinforce the idea that the student continually makes choices, and then move to making “better” choices.
- Choose your battles.
- Build self-esteem in the student.
- Provide movement activities – dancing, rhythmic movement, sitting in a rocking chair.
- Insist on eye contact.
- Acknowledge good decisions and behavior; give matter-of-fact consequences for inappropriate behavior or poor decisions.
- Avoid harsh, punitive consequences, as those will only reinforce the student’s mistrust of adults.
- Do not accept slurred speech – ignore it (but be sure the student knows the acceptable response).
- Standard rewards don’t work (rewards, treats, etc.).
- Be consistent and specific. Do not cut the student any “slack”, as he/she will probably view that as room to manipulate or try to regain control.
- Use a team approach – one person should not be responsible alone.
- Avoid being alone with the student (you want to avoid false accusations).
- Reinforce that you (the teacher) are in charge – have the student repeat that (“yes, Mrs. Smith, you are the boss”) but don’t be sarcastic or argumentative. Insist on the use of titles to reinforce rank (Mrs. Smith, Coach Jones).
- Use natural consequences when possible (“You made a mess. Clean it up”).
- Record assignments for the student if he/she has difficulty remembering them.
- Have a crisis plan, including a place the student can go to regain control if need be.
- If the student is at a point in therapy where it is acceptable, work on social skills and group skills.
- If the student is stressed, try to determine if he/she is bored or overwhelmed and adjust accordingly.
Summary

- Treatment is challenging and difficult. Close collaboration between the family and the mental health professionals is critical for a successful future.
- It takes a great deal of work and time for treatment to be successful – parents may not have the energy to focus on anything else for the time being. School staff should support and respect that.
- Students with a mental health diagnosis do not automatically qualify for special education under the Individuals with Disabilities Education Act (IDEA). Keep in mind that IEP (Individualized Education Program) teams cannot make DSM-IV diagnoses, and physicians cannot identify a child as having special education needs under IDEA. If a student with a mental health diagnosis does not qualify for special education under IDEA, schools may serve these students in their regular education programs or using a 504 Plan. (see “Background Information” Fact Sheet).
- Communication with the family and the student’s mental health team (physician, therapist, etc.) is critical. It is important for school personnel to know the possible side effects of medications the student is taking, as well as how the disease is manifested for that student.
- Conduct an FBA to help determine triggers/antecedents, as well as maintaining consequences. This includes developing a hypothesis as to whether the behavior is symptomatic, learned, or a combination. Observe the student, gather anecdotal information, and interview teachers, other staff, parents, the student (if appropriate) and the therapist. Then develop a behavior plan which can be tested to see if the behavior can be modified.

Selected Resources

Attachment Disorder Site. Downloaded 9/04 from www.attachmentdisorder.net


Reactive Attachment Disorder (RAD) aka Attachment Disorder (AD). A Power Point presentation downloaded 9/04 from http://radclass.tripod.com

