Reactive Attachment Disorder (RAD)

Information for Teachers

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Child and Adolescent Mental Health Problems – Fact Sheets for School Personnel: Reactive Attachment Disorder (RAD)

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- 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 is 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 do 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

IEP Ideas. Downloaded 9/04 from http://attachment.adoption.com/example_iep.php

The New and Approved Children Who Shock and Surprise: A Guide to Attachment Disorders. Elizabeth Randolph. 2002. RFR Publications, Evergreen, CO.

Overview of Reactive Attachment Disorder for Teachers. Downloaded 9/04 from http://attachment.adoption.com/letter_teacher.php

Reactive Attachment Disorder. American Academy of Child and Adolescent Psychiatry. Downloaded 9/04 from www.aacap.org/publications/factsfam/85.htm

Reactive Attachment Disorder (RAD). Children's Mental Health Fact Sheet for the Classroom. Minnesota Association for Children's Mental Health. Downloaded 9/04 from www.macmh.org

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

Reaching Angry and Unattached Kids. Fred G. Tully and Larry K. Brendtro. *Reclaiming Children and Youth,* Vol. 7, No. 3, Fall 1998. Pages 147-154.

Teaching Teachers. Downloaded 9/04 from http://attachment.adoption.com/teaching.php

When Love is Not Enough: A Guide to Parenting Children with RAD-Reactive Attachment Disorder. Nancy L. Thomas. 1997. Families by Design, Glenwood Springs, CO. www.attachment.org

Five Things Teachers Need to Know

1. Please do not hug or show special affection to my child. She needs to understand that those things are for family first.

2. My child may tell stories about things that happen in our family that are not true. Please consult me before acting on them.

3. My child can be very manipulative. For your own protection, do not allow yourself to be taken in.

4. My child is loved by his family. The precautions we are taking are to ensure his safety and emotional health, and the family stability required to provide that.

5. Please keep the lines of communication open between our home and the school. My child needs all the adults in her life working together.

An Overview of Reactive Attachment Disorder for Teachers

If a parent has given you this to read, you are teaching a child with **Reactive Attachment Disorder**. The family of this child has apparently decided to share this information with you. That sharing is a big step for this family and one you have to treat gently and with the respect it deserves.

Reactive Attachment Disorder (RAD) is most common in foster and adopted children but can be found in many other so-called "normal" families as well due to divorce, illness or separations. Reactive Attachment Disorder (RAD) develops when a child is not properly nurtured in the first few months and years of life. It is causes by early chronic maltreatment such as neglect, abuse, or institutional care. The child, left to cry in hunger, pain or need for cuddling, learns that adults will not help. The child whose parent(s) are more involved in getting their next drug fix than they are in nurturing the developing child learns that the child's needs are not primary to the caregivers. Children born of drug or alcohol addicted parents learn even in the womb that things do not feel good and are not safe for them. In severe cases, where the child was an abuse or violence victim, the child learns adults are hurtful and cannot be trusted. ~~The child~~ with RAD may develop approaches or "working models" of the world to keep the child safe. The child may try to control a world the child experiences as dangerous if not controlled by the child. Without therapy child with RAD may not develop the attachments to other human beings which allow them to trust, accept discipline, develop cause and effect thinking, self-control and responsibility.

Children with RAD are often involved in the Juvenile Justice System, as they get older. They feel no remorse, have no conscience and see no relation between their actions and what happens as a result because they never connected with or relied upon another human being in trust their entire lives.

What you may see as a teacher is a child who is, initially, surprisingly charming to you, even seeking to hold your hand, climbing into your lap, smiling a lot, you're delighted you are getting on so well with such a child. At the onset of your contact with the child who has been reported from prior grades as "impossible" you will wonder what those previous teachers did to provoke the behaviors you have not (yet) seen but which are reflected in the prior grade reports. A few months into what you thought was a working relationship the child is suddenly openly defiant, moody, angry and difficult to handle; there is no way to predict what will happen from day to the next; the child eats as if he hasn't been properly fed and is suspected of stealing other children's snacks or lunch items; the child does not seem to make or keep friends; the child seems able to play one-on-one for short periods, but cannot really function well in groups; the child is often a bully on the playground; although child ~~with~~ RAD may have above average intelligence they often do not perform well in school due to lack of problem solving and analytical thinking skills; they often test poorly because they have not learned cause-effect thinking. In addition, having experienced at an early age that

nothing they do matters, they do not "try" or put in effort; why try when what you do has not effect?

A child with RAD may climb into your lap and pretend to be affection starved. Children with RAD may talk out loud in classrooms, do not contribute fairly to group work or conversely argue to dominate and control the group. Organizational abilities are limited and monitoring is resented. There may be a sense of hypervigilance about them that you initially perceive as no sense of personal space and general "nosiness". They seem to want to know everyone else's business but never tell you anything about their own. There is no sense of conscience, even if someone else is hurt. They may express an offhand or even seemingly sincere "sorry," but will likely do the same thing again tomorrow. They are not motivated by self or parental pride, normal reward and punishment systems simply do not work.

They may omit parts of assignments even when writing their names just so that they are in control of the assignment, not you. This stems from a deep feeling that adults are not to be trusted, so the best strategy when you don't trust someone may be to not do what that person asks you to do. When assigned a seat they may choose an indirect, self- selected path to reach the seat. When given a certain number of things to repeat or do, they often do more, or less than directed. They destroy toys, clothing, bedding, pillows, and family memorabilia. They may blame parents, siblings, or others for missing or incomplete homework, missing items of clothing, lost lunch bags, etc. They may destroy school bags, lose supplies, steal food, sneak sweets, break zippers on coats, tear clothing, and eat so as to disgust those around them (open mouth chewing, food smeared over face).

They may inflict self-injuries, pick at scabs until they bleed, seek attention for non-existent/miniscule injuries, and yet will seek to avoid adults when they have real injuries or genuine pain. These children have not learned how to seek and accept comfort and care from caregivers because their early experiences have taught them that adults don't care. Children with RAD may have multiple falls and accidents and frequently complain about what other children have done to them ("he started it!", "Suzy kicked me first"). Children with RAD can walk around in significant physical pain from real injuries and may minimize the injury until it is detected. They may not wipe a running nose or cover a mouth to sneeze or conversely will overreact or exaggerate a cough or mild illness. They often have not had experiences of being taught in a loving responsive manner how to wash, bathe, brush teeth, and engage in other self-care activities.

They are in a constant battle for control of their environment and seek that control however they can, even in totally meaningless situations. If they are in control they feel safe. If they are loved and protected by an adult they are convinced they are going to be hurt because they never learned to trust adults, adult judgment or to develop any of what you know as normal feelings of acceptance, safety and warmth. Their speech patterns are often unusual and may involve talking out of turn, talking constantly, talking nonsense, humming, singsong, asking unanswerable or obvious questions ("Do I get a drink any time today?"). They have one pace - theirs. No amount of "hurry up everyone is waiting on you" will work - they must be in control and you have just told them they are. Need the child to finish lunch so everyone can go to the playground. Need the child to dress and line up, the child may scatter papers, drop clothing, fail to locate gloves, wander around the room - anything to slow the process and control it further. Five minutes later the child may be kissing your hand or stroking your cheek for you with absolutely no sense of having caused the mayhem that

ensues from his actions. Again all these behavior are NOT intentional. The behaviors are the result of having experienced significant early chronic maltreatment. These early experiences have created an internal working model of the world and relationship that mirror those early experiences and which are projected onto current relationships.

You can begin to understand what this child's parents must face on a daily basis. The parents are often tense; involved in control battles for their parental role every minute they are with the child, they adopted the child thinking love would cure anything that had happened to her before the adoption. They have only recently learned that normal parenting will not work with this child; that much of what they have tried to do for years simply fed into the child's dysfunction. They are frightened, sad, stressed and lonely. Many feel unmerited guilt for their perceived "failure" with this child. The mothers often bear the brunt of the child's actions.

It takes a tremendous amount of work and therapy to turn these kids around so that they can experience real feelings and learn to trust. Parents who have embarked on this healing journey for their child need support and consistency from other adults who interact with the child.

What can you do as a teacher? CALL THE PARENTS. Have them in to talk with you about this issue. Call them and talk about what you see in the classroom and ask if they have any other strategies for managing things. Parents who are in counseling and therapy with this child will eventually open up to you and you'll all be able to help the child get healthy or at least not contribute to his dysfunction.

Parents will tell you if time is precious on a particular occasion due to ongoing therapy, or whatever, don't feel put off or shut out. They will talk to you when they have time and time is one of the things parents often run out of as they work desperately to save their child's future. The therapy and home parenting techniques are exhausting and time consumptive. Try to respect that if it seems they are not focusing on your goal of home or class work. Do not trust schoolbag communication or expect things sent in a "communication envelope" to be as complete as when they left the school with the child. Use the phone, e-mail, and regular mail - it works.

Don't feel you need to apologize if you have believed this child and blamed the parents. If they have given you this information they already trust you and do not blame you for not having the information you needed - likely they only just recently got it themselves. **Make it perfectly clear in your interactions with the child that you will take care of the child and the classroom or activity.** Remind the child, unemotionally but firmly, that you are the teacher, you make the rules. You can even smile when you say it if you can get the "smile all the way up to the eyes", just remember to get the child to verbally acknowledge your position. Do it every day for a while, and then use periodic reminders. Insist upon use of titles or prefixes (Miss Jane, Teacher Sarah, Ms. Philips), they establish position and rank. Structure choices so that you remain in control ("do you want to wear your coat or carry it to the playground?" "you may complete that paper sitting or standing", "you may complete that assignment during this period or during recess"). Remember to keep the anger and frustration the child is seeking out of your voice. Try to "smile all the way to your eyes" if you can, otherwise simply stay as neutral as you can. Structure and control without threat.

YOU ARE NOT THE PRIMARY CAREGIVER for this child. You cannot parent this child. You are the child's teacher, not therapist, nor parent. Teachers are left behind each year, its normal. These children need to learn that lesson.

Establish EYE CONTACT with this child. Be firm, be consistent, and be specific.

Try to remember to **ACKNOWLEDGE GOOD DECISIONS AND GOOD BEHAVIOR**

CONSEQUENCE POOR DECISIONS AND BAD BEHAVIOR. Poor decisions and choices like incomplete homework, wrong weight jacket for the weather, also need to be acknowledged ("I see you didn't complete work from this activity period. You may finish it at recess while the other children who chose to finish their work go outside and play.") Nothing mean or angry or spiteful - it's just the facts. Remember they have difficulty with cause and effect thinking and have to be taught consequences. Normal reward systems like treats and stickers simply do not work with these children. Standard behavior modification techniques do not work with this child.

Consequencing is a good teaching technique- there is a consequence associated with each good behavior, each poor behavior - teach them what those consequences are - they will not think of or recognize them without your direction.

BE CONSISTENT, BE SPECIFIC. The child with RAD may be "good" for you one or two days or even weeks and then fall apart. This is normal. No general compliments like "you're a good boy!" or "You know better." Be specific and consistent - confront each misbehavior and support each good behavior with direct language. "You scribbled on the desk - you clean it up", "You hit Timmy, you sit here next to me until I decide you may play again without hitting." "You did well on the playground today, good for you!" "You completed that assignment, that's a good choice!" Be positive when you can.

This **NATURAL CONSEQUENCES** thing is important. Do not permit this child to control your behavior by threatening to throw a tantrum (let him, out in the hallway or in another room -"You can have your tantrum here if you choose to"). "I see you've wet the rug, here is a rag and bucket to clean it up", or puttering around doing his own thing when it delays the class' departure for a planned activity ("I see you've not gotten ready to go, you can wait here in the supervisor's office until we get back").

Time-outs do not work for these children - they want to isolate themselves from others. Bring the child near the activity he has had to be removed from and have them stand with or sit in a chair along side you. It's called a **"TIME-IN."** If you can take the time, speak quietly about how much fun the other children are having and how sad it is that she cannot join in right now. No raised voices, no anger. Don't lose your temper if you can avoid it; remember he is manipulating you to do just that. If you are going to lose it, seek assistance from another adult until you are back in control of yourself.

RESPONSIVE, ATTUNED, EMOTIONALLY ENGAGED INTERACTIONS with this child. It is very important that this child experience positive regard and that the child is good, even is

the behavior is not acceptable. This helps the child move from feeling overwhelming shame to experiencing guilt.

SUPPORT THE PARENTS. The child who is losing control at home and in the classroom because folks are "on to him" will get a whole lot worse before he gets better. Listen appropriately. Absolutely redirect this child to parents for choices, hugs, decision-making and sharing of information you believe is either not true or is designed to shock or manipulate you. Follow up with the parents.

REMAIN CALM AND IN CONTROL OF YOURSELF. No matter what the child does today. If the child manages to upset you, the child is in control, not you. Remove yourself or the child from the situation until you are able to cope. The child may push your "buttons." But remember, these are YOUR buttons and it is your job as a professional to disconnect the buttons so that pressing them has no negative effect.

If your classroom is out of control because of this child, get help. Many school counselors and administrators have not had exposure to the RAD diagnosis or how to handle it in schools. There are many resources available. Don't give up. These children are inventive, manipulative and very much in need of everything you can offer to help them get healthy. Remind the child you will be speaking with her parents on a regular basis. Report to the child's home as often as you can without feeling burdened by the effort. Expect notes to be destroyed. Use the phone. If you do not get a response to written communication and the parents seem to be out of touch with general information, do not blame them. Chances are they never got the message, never saw the right number of papers and have no clue what is going on because that is just how the child likes it. It takes control from the parent. Give it back by communicating directly whenever possible.

This child can and will be helped to get healthy and you can be a part of that process with the right tools. Keep in touch with the family. Remember that what you see in school is only the tip of the iceberg - family life is terribly threatening to these children and what the parents have to deal with every day is nearly unimaginable to other uninformed adults. Blaming the family or failing to communicate with them adds to the dysfunction and puts the child at greater risk of never getting healthy. This child is learning in therapy to be respectful, responsible and fun to be around. It will take time, it will be an effort, if in the end it is successful it will be because the adults in her life were consistent and the child decided to work in therapy. Your contribution as his teacher cannot be underestimated or undervalued - his parents will be grateful for the support and the therapist will have fewer inconsistent venues to sort out while helping the child to heal.