Attachment Difficulties, Childhood Trauma, and Reactive Attachment Disorder: Clinical Guidelines for Assessment, Diagnosis and Treatment

Day 2

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Objectives:

- Describe the diagnosis of Reactive Attachment Disorder and differentiate those symptoms from those of other diagnoses which can or have been purported to share features with or may be comorbid with RAD.
- Become better consumers or providers for children with attachment and trauma histories.
- Increase knowledge of the use of treatment guidelines and evidenced based treatment interventions for problems stemming from trauma and attachment issues.

Many Potential Problems of Institutionalization

- Lack of attachment relationship
- Malnutrition
- Lack of cognitive and physical stimulation
- Lack of physical affection and touch
- In utero teratogenic exposures
- Lead poisoning
- Lack of medical care
- Maltreatment by peers and caregivers
RAD is NOT simply a result of the many problems of institutionalization

- Children in Tizard’s study had adequate nutrition and social and play opportunities
- Animal research supports idea that attachment impacts neurobiological functioning when controlling for other factors (Suomi, 1999)

Psychiatric Differential Diagnosis

Differential Diagnoses

- Actual diagnostic criteria
  - Pervasive Developmental Disorder
  - Mental Retardation
  - Attention Deficit Hyperactivity Disorder
  - Medical conditions
    - Fetal alcohol syndrome
    - Williams syndrome
- Invalidated extension of diagnostic criteria
  - PTSD/Anxiety
  - Oppositional Defiant Disorder/Conduct Disorder
  - Bipolar Disorder
  - Environmental adaptation
**How do we differentially diagnose?**

- Withdrawn/inhibited type shares features of Autism Spectrum Disorders:
  - Impaired or absent social and emotional reciprocity
  - Emotional regulation
  - Frequently cognitive delays
  - Self-stimulating behaviors
- RAD Differs from ASD:
  - No permanent impairment in pretend play
  - No repetitive preoccupations
  - No language abnormalities, other than possible language delays
  - Should have a history of pathogenic care

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**How do we differentially diagnose?**

- Withdrawn/inhibited type shares features of Mental Retardation:
  - Cognitive delays
- MR Differs from RAD:
  - Developmentally appropriate social and emotional behavior seen in kids with MR
- CONDITIONS MAY CO-OCCUR

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**How do we differentially diagnose?**

- Disinhibited type shares features of ADHD:
  - Inattention
  - Hyperactivity
  - Disinhibited behavior
- RAD ADHD-like behaviors only in social relationships and not in other contexts
- CONDITIONS MAY CO-OCCUR
How do we differentially diagnose?

- Disinhibited type shares features of Williams Syndrome (chromosomal anomaly):
  - Indiscriminate behavior
  - Unable to distinguish threatening faces
  - Verbally engaging strangers

- Disinhibited type shares features of Fetal Alcohol Syndrome:
  - Indiscriminate behavior
  - Cognitive abnormalities
  - Talkative, outgoing, affectionate and overly friendly to strangers

- Is it RAD or is it FAS or is it both?

Invalidated Extension of Diagnosis

- Self-destructive behavior
- Destruction of property
- Consistently irresponsible
- Inappropriately demanding/clingy
- Stealing
- Deceitful
- Hoarding
- Inappropriate sexual attitudes
- Cruelty to animals
- Sleep disturbance
- Enuresis/encopresis
- Frequently defies rules
- Abnormal eating habits
- Preoccupation with fire, gore and evil
- Persistent nonsense questions and incessant chattering
- Poor hygiene

(Levy and Orlans)
Invalidated Extension of Diagnostic Criteria: Could it really be…?

- PTSD: Experience causing fear for one’s life (emotional or literal)
  - Avoidance
  - Re-experiencing
  - Hyper-arousal
- Anxiety
  - Inappropriately demanding and clingy
  - Self-destructive behavior
  - Enuresis
  - Encopresis
  - Abnormal eating habits
  - Persistent nonsense questions and incessant chattering
  - Difficulty with novelty and change

The following slides are taken from Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents (2010)
How Children Respond to Trauma

Hyperarousal:
- Nervousness
- Jumpiness
- Quickness to startle

Reexperiencing:
- Intrusive images, sensations, dreams
- Intrusive memories of the traumatic event or events

Avoidance and withdrawal:
- Feeling numb, shut down, or separated from normal life
- Pulling away from activities and relationships
- Avoiding things that prompt memories of the trauma
What You Might See: Reactions to Trauma Reminders

Trauma reminders: Things, events, situations, places, sensations, and even people that a child connects with a traumatic event.

(Continued)

Reactions to Trauma Reminders
(Continued)

- Reexperiencing
- Withdrawal
- Disassociation

I don’t think there was a time when I wasn’t abused as a child. In order to survive the abuse, I made believe that the real me was separate from my body. That way, the abuse was happening not really to me, but just this skin I’m in.

—C. M.
What about Posttraumatic Stress Disorder?

Posttraumatic stress disorder (PTSD) is diagnosed when:

- A person displays severe traumatic stress reactions,
- The reactions persist for a long period of time, and
- The reactions get in the way of living a normal life.

What You Might See: Traumatic Stress Reactions

- Problems concentrating, learning, or taking in new information
- Difficulty going to sleep or staying asleep, nightmares
- Emotional instability; moody, sad, or angry and aggressive, etc.
- Age-inappropriate behaviors; reacting like a much younger child

What You Might See: Traumatic Play

When playing, young children who have been through traumatic events may:

- Repeat all or part of the traumatic event
- Take on the role of the abuser
- Try out different outcomes
- Get “stuck” on a particular moment or event

(Continued)
**Traumatic Play (Continued)**

Seek professional help if your child:
- Centers most play activities around traumatic events
- Becomes very upset during traumatic play
- Repeatedly plays the role of the abuser with dolls or stuffed animals or acts out abuse with other children
- Plays in a way that interferes with relationships with other children

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**What You Might See: Talking About Trauma**

- Talking about certain events all the time
- Bringing up the topic seemingly “out of the blue”
- Being confused or mistaken about details
- Remembering only fragments of what happened
- Avoiding talk about anything remotely related to the traumatic events
Vicious cycle of the acting out “bad” child

“Bad” child

“I was treated bad.”

Abuse, neglect, multiple placements

Negative working model

“I am bad, unlovable. Caregivers are unsafe, unreliable.”

Conduct Disorder

“I will act badly.”

Oppositional Defiant Disorder (DSM-IV)

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present: often loses temper

1) often argues with adults
2) often actively defies or refuses to comply with adults’ requests or rules
3) often deliberately annoys or irritates people
4) often blames others for his or her mistakes or misbehavior
5) is often touchy or easily annoyed by others
6) is often angry and resentful
7) is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a psychotic or mood disorder.

D. Criteria are not met for conduct disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial personality disorder.

Conduct Disorder (DSM-IV)

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals

1) often bullies people, threatens, or intimidates others
2) often initiates physical fights
3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun) (except for activities such as archery and hunting)
4) has been physically cruel to people
5) has been physically cruel to animals
6) has broken into someone’s home or car
7) has forced someone into sexual activity

Destruction of property

8) has deliberately engaged in setting the fire with the intention of causing serious damage
9) has deliberately destroyed other property (other than by fire)

Deceitfulness or theft

10) has stolen items of nontrivial value (e.g., shoplifting, but without breaking and entering; forgery)
11) has stolen items of trivial value (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

12) often stays out at night despite parental prohibitions
13) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
14) is often defiant toward adults, beginning before age 13 years

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial personality disorder.
Antisocial Personality Disorder (DSM-IV)

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by 3 (or more) of the following:
   1) Failure to conform to social norms with respect to lawful behavior as indicated by repeatedly performing acts that are grounds for arrest
   2) Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
   3) Impulsivity or failure to plan ahead
   4) Irritability and aggressiveness, as indicated by repeated physical fights or assaults
   5) Reckless disregard for safety of self or others
   6) Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
   7) Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years

C. There is evidence of Conduct Disorder with onset before age 15 years

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode

Bipolar Disorder (DSM-IV)

What's the most recent episode?
Have you seen one full-blown manic episode before this current situation?

Mania:
- A distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting at least one week (or any duration if hospitalization is necessary)
- During period of mood disturbance, 3 or more of the following have persisted (4 if mood is only irritable) and have been present to a significant degree:
  1. Inflated self-esteem or grandiosity
  2. Decreased need for sleep (feels rested after only 3 hours of sleep)
  3. More talkative than usual or pressure to keep talking
  4. Flight of ideas or subjective experience that thoughts are racing
  5. Distractibility (attention is easily drawn to irrelevant or unimportant stimuli)
  6. Increased goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  7. Excessive involvement in pleasurable activities that have a high potential for painful consequences

(Episodes represent a significant departure from the individual’s baseline function)

Hospitalizations and a History of Child Abuse

- Mayo Clinic study presented at the American Psychiatric Association 2009 Annual Meeting in San Francisco (Romanowicz, et. al.)
- History of child abuse
  - increased risk of suicide attempts
  - substance abuse
  - earlier onset of mental illness
  - more psychiatric hospitalizations
Environmental Adaptation

- Stealing
- Deceitful
- Hoarding
- Sleep disturbance
- Abnormal eating habits
- POOR HYGIENE

Early Chronic Interpersonal Trauma

- Disorganized Attachment
- Oppositional Defiant Disorder (earlier onset worse prognosis; 3X more likely to develop CD)

- Conduct Disorder (for about 30% of ODD kids)

- Antisocial Personality Disorder (for about 10% of ODD and 40% of CD kids)

14% comorbid ADHD, 14% anxiety, or 9% mood disorders (caution: oppositional behavior may be used to manage anxiety/depression in the face of overwhelming demands)

(As described in Lyons-Ruth & Jacobvitz, 2008; ACAP Practice Parameters for ODD, 2007)

Being Good

Consumers/Providers of Mental Health Treatment
Being Good Consumers/Providers of Mental Health Treatment

1. Evaluate the quality of the diagnostic assessment.
2. Evaluate what kinds of services the child has received already.
   • Distinguish vehicles for services from actual services
   • Evidence-based practices vs. "regular treatment"
3. Advocate for appropriate interventions

Step 1: Evaluate the quality of the diagnostic assessment
■ Is the professional qualified to make a diagnosis?
  – License in field
  – Expertise in field
  – If it sounds crazy, it might be!
    ■ You can’t diagnose a mental health condition with a brain scan.
    ■ All attachment problems are not RAD or even DSM diagnosable conditions!
■ Did the professional use best practices of assessment?

(American Academy of Child and Adolescent Psychiatry)

AACAP Practice Parameters
■ Published over 30 Practice Parameters, including
  – Reactive Attachment Disorder of Infancy or Early Childhood
  – Oppositional Defiant Disorder
  – Conduct Disorder
  – Bipolar Disorder
■ Designed to assist clinicians in providing high quality assessment and treatment for children and adolescents that is consistent with the best available scientific evidence and clinical consensus
■ All available at http://aacap.org/page.ww?section=Practice+Parameters
  &name=Practice+Parameters
  or google “AACAP practice parameters”
NC RAD Guidelines
- NC Div of Mental Health, DD, SA Services endorsement of guidelines
  - Developed by Center for Child and Family Health

Mental Health Diagnosis is Not An Exact Science
  - Healthy associates or "pseudopatients" briefly simulated auditory hallucinations (heard a voice say, "empty," "dull," and "thud")
  - 8 were admitted to hospitals
  - All 12 diagnosed with psychiatric disorders
  - After admission, the pseudopatients acted normally and told staff that they felt fine and had not experienced any more hallucinations
  - Hospital staff believed all the pseudopatients exhibited symptoms of ongoing mental illness
  - Several confined for months
  - All were forced to admit to having a mental illness and agree to take antipsychotic drugs as a condition of their release

Clinical Assessment for Trauma and Attachment Issues
1. Direct observations
   - Primary caregivers and unfamiliar adults
   - Structured observational paradigm as in AACAP practice parameters
2. Collateral history
   - Current and historical attachment behaviors (0-5 years of age)
     - Disorder of Attachment Interview (Smyke, Zeanah, 2002)
     - Diagnostic Infant/Preschool Structured Interview attachment disorder module (Scheeringa, 2000)
     - Psychiatric Assessment Preschool Age attachment disorder module (Egger and Angold, 2004)
   - Exposure to traumatic events in early years
3. Assessment of the child across settings
Clinical Assessment continued

4. Psychological testing
   - Broad-band behavioral measure (CBCL, BASC, SDQ)
   - Trauma exposure screen (UCLA PTSD-RI, DIPA)
   - PTSD measure (UCLA PTSD-RI, TSCC, TSCYC, DIPA)
   - Parent distress in relationship with child (PSI)
   - Parenting (Alabama Parenting Questionnaire, Adult and Adolescent Parenting Interview)

5. Screening for developmental delays
   - Fetal alcohol syndrome, speech and language delays, medical conditions, pervasive developmental disorders
   - May require multidisciplinary team

Clinical Assessment continued

6. Cultural issues
   - International and cross-cultural placement issues (e.g., eye contact, personal space)
   - Culture of orphanage

7. Assessment, differential diagnosis, and risk/safety assessment
   - Psychiatric disorders affecting maltreated children
   - Increased risk of depression and suicide
   - Safety within parent-child relationship and others in home

Multi-disciplinary Approach
Necessary to Assess for:
- Lack of attachment relationship
- Trauma
- Malnutrition
- Lack of cognitive and physical stimulation
- Lack of physical affection and touch
- In utero teratogenic exposures
- Lead poisoning
- Lack of medical care
Being Good Consumers/Providers of Mental Health Treatment

1. Evaluate the quality of the diagnostic assessment.
2. Evaluate what kinds of services the child has received already.
   - Distinguish vehicles for services from actual services
   - Evidence-based practices vs. "regular treatment"
3. Advocate for appropriate interventions

Step 2

Evaluate what kinds of services the child has received already.

Distinction between vehicles for services and actual treatments

<table>
<thead>
<tr>
<th>Vehicles for Services</th>
<th>Actual Services</th>
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</thead>
<tbody>
<tr>
<td>Case management</td>
<td>Supportive, non-directive therapy &quot;not evidence-based&quot;</td>
</tr>
<tr>
<td>Outpatient therapy</td>
<td>Trauma-focused Cognitive Behavioral Therapy</td>
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<tr>
<td>- Individual</td>
<td>Parent-Child Interaction Therapy</td>
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<tr>
<td>- Family</td>
<td>Multisystemic Therapy</td>
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<tr>
<td>- Play</td>
<td>Child-Parent Psychotherapy</td>
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<td>- Group</td>
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<tr>
<td>Parenting/Behavior</td>
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<tr>
<td>Management</td>
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<td>Intensive in home</td>
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<td>Residential</td>
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<tr>
<td>Hospitalization/ Inpatient</td>
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What is Evidence-Based Practice?

- Sound theoretical basis
- Clinical literature regarding efficacy
- Accepted in clinical practice
- No evidence of substantial harm or risk
- Manual sufficiently detailed to allow replication
- Efficacy based on at least 2 randomized, controlled trials
- Majority of outcome studies support efficacy
- Recognized by national objective organization

National Objective Organizations

- California Evidence Based Clearinghouse
  - 1-5 rating scale based on support for practice of scientific evidence
- National Registry of Evidence-based Programs and Practices (SAMHSA)
  - [www.nrepp.samhsa.gov/](http://www.nrepp.samhsa.gov/)
  - Effective programs and promising programs
- Office of Juvenile Justice and Delinquency Prevention Model Programs
  - [www.dsgonline.com/mpg_non_flash/mpg_index2.htm](http://www.dsgonline.com/mpg_non_flash/mpg_index2.htm)
  - Exemplary programs, effective programs and promising programs

AACAP Indicated “Exemplary Programs” for ODD

- Incredible Years (up to age 8)
- Triple P-Positive Parenting Program (up to age 13)
- Parent-Child Interaction Therapy (up to age 7)
- Helping the Noncompliant Child: Parenting and Family Skills Program (up to age 8)
- COPE (up to age 12-14)
- Defiant Children* (up to 12, Defiant Teens for ages 13 to 18)
- The Adolescent Transitions Program (ages 11-13)

Note: Prevention is a key element in ODD and other DBD intervention (Burke et al., 2002; Connor, 2002; Hinshaw and Anderson, 1996; Rutter et al., 1999)

*Does not have a randomized control trial
California Evidence Based Clearinghouse “Well-Supported” Treatments for Disruptive Behaviors

- Coping Power Program (ages 8-14)
- Multi-Systemic Therapy (ages 12-17)

Note: Prevention is a key element in ODD and other DBD intervention (Burke et al., 2002; Connor, 2002; Hinshaw and Anderson, 1996; Rutter et al., 1999)

Intervention: Higher Level of Placement
Being Good Consumers/Providers of Mental Health Treatment

1. Evaluate the quality of the diagnostic assessment.
2. Evaluate what kinds of services the child has received already.
   - Distinguish vehicles for services from actual services
   - Evidence-based practices vs. “regular treatment”
3. Advocate for appropriate interventions

Step 3

Advocate for appropriate interventions.

Treatment Principles

1. Provision of a stable, safe, nurturing and lovable primary caregiver
   - Sensitive to child’s signals
   - Gently challenge child’s miscues that nurturance is not needed
   - Evidence-based models: Attachment and Biobehavioral Catch-up (Dozier, 2002) or Circle of Security (Hoffman, Marvin, Cooper, & Powell, 2006)
Treatment Principles continued

1. Provision of a stable, safe, nurturing and lovable primary caregiver (con’t.)
   - “Caregivers who are emotionally available and sensitively responsive, who know and value the child as an individual, and who place the needs of the child ahead of their own needs.” (Zeanah and Smyke, 2008)
   - Able to consistently make healthy attributions of child behavior

Treatment Principles continued

1. Provision of a stable, safe, nurturing and lovable primary caregiver (con’t.)
   - Able to provide emotional and physical consistency and predictability
     - Parent can demonstrate and effectively cope with a range of emotions
   - Able to facilitate child’s exploration and development

Caveat about Treatment Principle #1

- Remember withdrawn type RAD persists when children remain institutionalized, but disappears when their environment changes and a caregiver is provided (Zeanah et al., 2006). Thus when behavior persists following provision of primary caregiver in home setting, clinicians must consider alternative diagnoses regarding behavior.
Treatment Principles continued

2. Treatment must first and foremost be provided as early as possible.
   Treatment goals consist of
   ■ Understanding emotions, social cues, and interpersonal situations; and
   ■ Decreasing externalizing behavior problems, improving stranger safety, and checking back with caregiver when in need
   ■ Affect regulation and impulse control

Treatment Principles continued

3. Directly address trauma history if child has memory
   ❖ Evidence-based models: Child Parent Psychotherapy (Lieberman et al., 2005); Trauma-focused Cognitive-Behavioral Therapy (over age 3; Cohen, Mannarino, Deblinger, 2006)

4. Impart healthy messages about child’s biological parents (e.g., avoid “parents didn’t love you”); child is loveable and worthwhile despite parent’s abuse

5. Enriched environment

Additional Treatment Principles for Children >6 years of Age

■ Immediately address unsafe or high-risk behaviors
■ Psychopharmacologic assessment and treatment
Resource for Training Foster Parents about Trauma

  - PowerPoint-based training curriculum co-led by mental health clinician and foster parent
  - Help foster parents understand the link between trauma and their children’s baffling behavior, feelings, and attitudes
  - Provides practical tools
  - Facilitator’s Guide and training support is available through NCTSN

Trauma and Attachment Informed Caregiving

The following slides are taken from Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents (2010)
Getting Development Back on Track

- Traumatized children and adolescents can learn new ways of thinking, relating, and responding.
- Unlearning—and rebuilding—takes time.

What Trauma-Informed Parents Can Do

- Offer a secure base of love and protection.
- Be emotionally and physically available.
- Recognize and respond to the child’s needs.
- Provide guidance and example.
- Provide opportunities to safely explore the world.

Recovering from Trauma:
The Role of Resilience

- Resilience is the ability to recover from traumatic events.
- Children who are resilient see themselves as:
  - Safe
  - Capable
  - Lovable

Just as despair can come to one only from other human beings, hope, too, can be given to one only by other human beings.

—Elie Wiesel
Author, activist, and Holocaust survivor

Growing Resilience

Factors that can increase resilience include:

- A strong relationship with at least one competent, caring adult
- Feeling connected to a positive role model/mentor
- Having talents/abilities nurtured and appreciated
- Feeling some control over one’s own life
- Having a sense of belonging to a community, group, or cause larger than oneself
Safety and Trauma

- Physical safety is not the same as psychological safety.
- Your child’s definition of “safety” will not be the same as yours.
- To help your child feel safe, you will need to look at the world through his or her “trauma lens.”

(Continued)

Safety and Trauma (Continued)

Children who have been through trauma may:
- Have valid fears about their own safety or the safety of loved ones
- Have difficulty trusting adults to protect them
- Be hyperaware of potential threats
- Have problems controlling their reactions to perceived threats

(Continued)

When supper was over I saw that there were many biscuits piled high upon the bread platter, an astonishing and unbelievable sight to me. . . .

I was afraid that somehow the biscuits might disappear during the night, while I was sleeping. I did not want to wake up in the morning, . . . feeling hungry and knowing that there was no food in the house. So, surreptitiously I took some of the biscuits from the platter and slipped them into my pocket, not to eat, but to keep as a bulwark against any possible attack of hunger. . . .

I did not break the habit of stealing and hoarding bread until my faith that food would be forthcoming at each meal had been somewhat established.

—Richard Wright

Promoting Safety

- Help children get familiar with the house and neighborhood.
- Give them control over some aspects of their lives.
- Set limits.
- Let them know what will happen next.
- See and appreciate them for who they are.
- Help them to maintain a sense of connection and continuity with the past.

Give a Safety Message

- Partner with the social worker or caseworker.
- Get down to the child’s eye level.
- Promise to keep the child physically safe.
- Ask directly what the child needs to feel safe.
- Follow the child’s lead.
- Let the child know that you are ready to hear what he or she needs.

Give a Safety Message (Continued) (Group Activity)

Take concerns seriously:
- Empathize.
- Acknowledge that the child’s feelings make sense in light of past experiences.
- Be reassuring and realistic about what you can do.
- Be honest about what you do and don’t know.
- Help your child to express his or her concerns to other members of the child welfare team.
Explain Rules

When explaining household rules:

- Consider the child's history.
- Don't overwhelm the child.
- Emphasize protection.
- Be flexible when you can.

Be an “Emotional Container”

I started cursing at the foster mom. I wanted her to lose control. I figured that sooner or later she would say something that would hurt me. I wanted to hurt her first . . .

Later, I felt depressed. I knew I'd acted out of control. When I get angry I don't even realize what I do and I hurt the people around me. . . .

I feel sad that I'm not good about expressing myself. I feel like a walking time bomb. I hope I can find a foster mom who can handle my anger, and help me take control of myself.

—A. M.
Be an “Emotional Container”

(Continued)

- Be willing—and prepared—to tolerate strong emotional reactions.
- Remember the suitcase!
- Respond calmly but firmly.
- Help your child identify and label the feelings beneath the outburst.
- Reassure your child that it is okay to feel any and all emotions.

Manage Emotional “Hot Spots”

- Food and mealtime
- Sleep and bedtime
- Physical boundaries, privacy, personal grooming, medical care

I made a list of things my sister and I eat so [our new foster mother] could buy our food, but she didn’t buy exactly what we wanted.

She bought the wrong kind of cereal, she put ginger in the juice even though I told her not to, and the bread was some damn thick . . . bread.

All of these little things made me furious. I believed she thought it didn’t matter what I told her, and that she could treat us how she wants.

—A. M.
Food and Meals (Group Activity)

- Be aware of the child's history.
- Accommodate food preferences, if possible.
  - Set consistent meal times.
  - Involve child in planning and making meals.
  - Keep mealtimes calm and supportive.

I woke up in a panic. I couldn't stay asleep. [My foster mother] came into my room. "Honey, what's wrong?"

I couldn't even tell her how I felt. I couldn't get the words out to say what was the matter.

—A. M.


Sleep and Bedtime (Group Activity)

(Continued)
Sleep and Bedtime (Continued)

- Help your child to “own” the bedroom.
- Respect and protect your child’s privacy.
- Acknowledge and respect fears.
- Set consistent sleep and wake times with predictable, calming routines.
- Seek help if needed.

I don’t think there was a time when I wasn’t abused as a child. In order to survive the abuse, I made believe that the real me was separate from my body. That way, the abuse was happening not really to me, but just this skin I’m in.

Still, my body sometimes betrayed me. Crying when I wanted to remain strong, becoming tired and refusing to obey my commands to stay awake, and, most horribly, physically responding to sexual advances. It seemed to me like my body had a mind of its own. I hated the thought of sexual contact, yet my body would respond to it, even when it was unwanted.

—C. M.

Physical Boundaries

Children who have been neglected and abused may:

- Never have learned that their bodies should be cared for and protected
- Feel disconnected and at odds with their bodies
- See their bodies as “vessels of the negative memories and experiences they carry, a constant reminder not only of what has happened to them but of how little they are worth”

Controversial Practices

Controversies in Diagnosis and Treatment of RAD

- Issues about safety
  - Death of children undergoing “attachment therapy”

- Levels of care
  - Higher level with pattern of treatment failure in less intensive settings
    - Remember judge previous treatment failure on
      - Evidence-based practices
      - Vehicles for treatment vs. treatment modalities

- Assessment practices without validation
  - SPEC scans, “cross-crawlability,” Randolph Attachment Disorder Questionnaire

- Theoretical and intervention controversies
  - Interventions that promote safety, trust, and comfort with caregivers vs. use of pain, fear, and domination (“attachment therapy” based on “rage reduction theory”)
  - “Attachment therapy” purports to solve behavioral symptoms without empirical evidence (There are a number of evidence-based interventions that do address behavioral symptoms)
  - Belief that these children are so different from the rest of humanity is justification for
    - Not using traditional therapies
    - Extreme measures

- Levels of care
  - Higher level with pattern of treatment failure in less intensive settings

Remember judge previous treatment failure on
- Evidence-based practices
- Vehicles for treatment vs. treatment modalities
Front Line Skills: Managing Difficult Behaviors

Caregiver Attributions of Child Behavior & Behavior Management

Attributions

Why is it so hard to be logical when we parent?

Why is this child acting out?

- 3 year old boy is hitting his mother as she says goodbye to him at daycare
- 15 year old girl is sexually promiscuous and running away from her foster home even though she reports she really likes her foster mother
- 8 year old boy repeatedly getting up from his seat and disrupting math class by clowning around
How will you act if you think the child is being willful and bad? How will you act if you think the child is acting out of anxiety, fear, confusion or frustration?

**Vicious Cycle of the Acting Out “Bad” Child**

- “I was treated bad.”
  - Abuse, neglect, multiple placements

- Negative Responses
  - “Others treat me bad.”

- Negative working model
  - “I am bad, unlovable. Caregivers are unsafe, unreliable.”

- Conduct Disorder
  - “I will act badly.”

**Examples of Harmful Attributions**
Attributes Color Actions

- Behaviors we attend to
- Behaviors we ignore
- Meaning we assign to behaviors
- Consequences given
- Severity of consequences

Attributes Contribute to Behavioral Cycles

- Parent
  - Angry at child
  - Thinks child is bad
  - Feels incompetent
  - Doesn’t want to please child
- Child
  - Angry at parent
  - Feels unloved and ashamed
  - Doesn’t want to please parent

How do we change attributions?

- Get more information about the situation
- Behave our way into thinking differently
  - Practice
- Change our thoughts
Behavior Management

What would happen to us if the unpleasant things in our lives exceeded the rewards?
- Depressed/shut down
- Mad/seek out rewards regardless of the consequences
- It depends on...

What kinds of unpleasant things have the kids we are focusing on today experienced?
- Separation from parent
- Caregivers that fail to protect them, are violent, that don’t believe in/love the them, will send them away
- Other traumas

What kind of expectations do these kids have about their lives and how adults will treat them?

How do we change these expectations?
- Change their cognitions/expectations that are unhelpful
- Set up the environment using good behavior management principles to show them that they should have different cognitions/expectations
Environmental Conditions That May Make Behavior Erratic

- Sleep
- Food
- Structure/schedule
  - Child less likely to need a reason for the task/command
  - Group home versus home placement
  - Some children do fine without structure, but if there are problems work on this first
- Health issues

Rationale for Behavior Management Training

- Well established (AACAP) that caregiver behavior management training is essential to addressing disruptive behavior disorders
- AACAP summarized the key principles:
  1. Reduce positive reinforcement of disruptive behavior
  2. Increase reinforcement of prosocial and compliant behavior (caregiver attention is predominant)
  3. Apply consequences and/or punishment for disruptive behavior (time out, loss of tokens, and/or loss of privileges)
  4. Make caregiver response predictable, contingent, and immediate
- This approach breaks down
  1. child’s coercive response to parental demands
  2. caregivers unwittingly reinforcing the child’s noncompliance

Questions to Ask Yourself to Improve How a Child Minds You

- What happens if a child’s interactions with you are always commands?
- What do caregivers need to mix in with commands to make them more likely complied with when used?
  - Praises (the last thing we want to do with behaviorally disordered kids, but it’s the most effective)
  - Choices
  - Talk about or participate in child’s interests
- What does a child learn if a caregiver repeats a command over and over and…
  - eventually communicates a level of seriousness (yelling, threatening, going near the child)?
  - gives up?
Rationale for Caregiver Behavior Management Training

- Caregiver behavior management training is essential to addressing disruptive behaviors
- Key principles:
  1. Reduce positive reinforcement of disruptive behavior
  2. Increase reinforcement of prosocial and compliant behavior (caregiver attention is predominant)
  3. Apply consequences and/or punishment for disruptive behavior (timeout, loss of tokens, and/or loss of privileges)
  4. Make caregiver response predictable, contingent, and immediate

American Academy of Child and Adolescent Psychiatry, 2007
Practitioner Parameter for the Assessment and Treatment of Children and Adolescents with Oppositional Defiant Disorder

Getting Started with Behavior Management Work

1. Make a list of all the problem behaviors with the caregiver
2. Quickly determine which behaviors are ignorable and which will be directly addressed
3. Pick only 1 or 2 behaviors to modify at a time
   - Why not tackle all of them at first?
   - Why not start with the most bothersome behavior first?
4. Help caregivers (and yourself) be realistic about the speed of change
   - How long the child's been doing the behavior
   - How many previous failed attempts have been made to change the behavior
   - How quickly the child learns in general
   - Behavior often gets worse before it gets better

After you have chosen the 1 or 2 behaviors...

1. Determine how much the behavior is actually happening
   - Rather than just “he steals” is should be “about 1 x per week at school”
   - If you don’t start with a specific rate you can’t
     - measure if the behavior is getting better or
     - reinforce or consequence the child
After you have chosen the 1 or 2 behaviors...

2. (Attempt to) Determine the function of behavior with the caregiver

Antecedent
Behavior
Consequence (reinforcement or punishment)
– Attention getting? (whining, attitude, talking back)
– Escape/feeling incompetent? (work refusal, poor hygiene)
– Too many commands on child already, child feels no control
– Rewarding in and of itself? (cutting, stealing)
  – How can the rewards be removed? (e.g., does it give child control/attention that child longs for?)
  – How can the opposite behavior receive a better reward?
– Conflictual relationship with caregiver, child has lingering resentment/unmotivated to please/believes s/he is "bad"
  – You’ll have to fix this first!
  – Refocus attention on any instances of prosocial behavior

After you have chosen the 1 or 2 behaviors...

2. (Attempt to) Determine the function of behavior continued

– For most behaviors, AVOID asking the child why they display the behavior

Why should you avoid it?
1. 
2. 
3. 

– For behaviors that are ineffective coping mechanisms...
  ■ Therapy is the place to work on replacement behaviors
  ■ Monitor effective and ineffective coping mechanisms throughout treatment

After you have chosen the 1 or 2 behaviors...

3. Respond in Two Possible Ways

■ Purely ignore (if ADD praising positive opposite behavior change will be faster)
  – Ex. Young children: temper tantrums and whining;
    Adolescents: ______________

OR

■ Give the “full” treatment
  – Ex. anything not ignorable
    ❌ Consequence
    ❌ Praising positive opposite
    ❌ Ignoring
Purely Ignore

- Sounds easy, but harder to do than providing a consequence
  - Requires superb patience and faith
  - If the child doesn’t think you’re ignoring him/her you’re not doing it right
- Once you ignore, don’t cave or you’ll make it worse the next time
- BE PREPARED: Ignored behaviors will often get initially worse

Praising/Rewarding Positive Opposites

- The most advanced behavior management technique
- Redirecting your attention away from misbehavior to the prosocial skill
  - Running
  - Stealing
  - Forgetting homework
  - Bossiness
  - Public masturbation
- Give the child instruction on the prosocial skill first if needed
- Be on the lookout for them CONSTANTLY!
- Look for opportunities for the child to practice the appropriate behavior (cuing them first will aid in success)

Caregiver Buy-In for Praise

- What has worked for you to get caregivers to agree with you that praise is important to use?
Effective Praise

- Be enthusiastic
- Be genuine
- Be specific
- Be present-focused and purely positive (no back-handed compliments!!)
- Be consistent/predictable
- Be immediate
- Focus on effort not outcome

Effective Rewards

- Tailored specifically to the child
  - What does this child REALLY love?
- Positive parental attention is the best reward
- Privileges
- Small, realistic, frequent rewards work best
- Stay away from food and trinkets unless it’s an emergency!

Give the “Full” Treatment

- Consequence
- Praising/rewarding positive opposite
- Ignoring

- Remember: You can not MAKE another person (especially an adolescent!) do anything. You can only change your response.
Effective Consequences

- Natural consequences (use first if available, safe, and developmentally appropriate)
  - Consequence happens to the child without you
  - Ex. Child refuses food, goes hungry, eats later
  - Bad ex. Child (3 year old) misses event because took too long
- Logical consequences
  - Time out
    - Ages 2-6
  - Work chores
    - Ages 7-12
  - The “iron-clad contract”
  - Adolescence
- Ages 2-6
- Ages 7-12

Effective Consequences cont.

- Immediate
- Consistent
- Developmentally appropriate
- Tailored specifically for the child
- Short term (if not, you punish yourself as well)
- Provided without extra comment
- Provided in a neutral tone of voice
- DON’T HOLD A GRUDGE- clean slate
- Effective repair following consequence

Many Ways to Mess Up Commands: Do This

- Cue child to pending command: “Owen, please…”
- Make it simple
- Make it developmentally appropriate
- Phrase it positively
- Give it in a neutral tone of voice
- Provide an explanation BEFORE command is given
- Give one command at a time
- Praise immediately after compliance
When no compliance:

- Limit warnings to ONE!!!!!
- "Sally, if you don’t do this behavior you will be given this consequence."

Evidence-Based Models at a Glance

In order by age of child

Attachment and Biobehavioral Catch-Up (ABC)
Mary Dozier

*Center for Child and Family Health is in the process of becoming trainers in this model.
The Evidence Base for ABC
- Rated as a promising practice:
  - 3 RCTs
  - 1 with one month follow up
  - None had 6 month+ follow up

ABC: Just the facts
- For foster parents of infants 0-2
- Modified version for physically abusing parents with children 0-2
- 10 one hour sessions
- Homework
- Parent and child generally seen together
- Parent periodically seen separately
- Research base on in-home setting

ABC: Four Goals
- Help foster parents override what may be their natural tendency to turn away from a distressed infant
- Help foster parents nurture an infant who appears to reject that nurturing
- Help foster parents provide as predictable an interpersonal environment as possible to help child better regulate their emotions, behaviors and physical responses
- Help foster parents provide non-threatening, safe environment
Child Parent Psychotherapy (CPP)
Alicia Lieberman and Patricia Van Horn

*Center for Child and Family Health can provide training in this model.

The Evidence Base for CPP
- Rated as 2- supported by research evidence:
  - 5 RCTs
  - 1 with 6 month+ follow up

CPP: Just the facts
- For children 0-6 who have experienced trauma
- 50 one hour sessions (efficacy of 25 sessions currently being studied)
- No homework
- Parent and child generally seen together
- Parent periodically seen separately
- Research base on clinic and in home settings
**CPP: Goals**

- Encouraging normal development: engagement with present activities and future goals
- Maintaining regular levels of affective arousal
- Establishing trust in bodily sensations
- Achieving reciprocity in intimate relationships

**CPP: Trauma-related Goals**

- Increased capacity to respond realistically to threat
- Differentiation between reliving and remembering
- Normalization of the traumatic response
- Placing the traumatic experience in perspective

**Bucharest Early Intervention Project**

- Train network of foster parents in attachment principles
- Provide salaries, material supports, and 24/7 pediatrician access
- Social work visits every 10-14 days to
  - monitor development and behavior and the developing attachment relationship
  - Normalize caregiver stress
  - Provide positive discipline strategies
  - Encourage communication (turn-taking, pretend play, etc.)
- Foster parent support group
Parent Child Interaction Therapy (PCIT)
Sheila Eyberg

*Center for Child and Family Health can provide training in this model.

The Evidence Base for PCIT
- Rated as 1 - well supported by research evidence:
  - 4 RCTs
  - 2 with 6 month+ follow up

PCIT: Just the facts
- For children 3-6 (2-7) with behavioral problems (ADHD, ODD)
- Modified version for physically abusing parents with children 4-12
- 10-20 one hour sessions
- Homework
- Parent and child generally seen together
- Parent periodically seen separately
- Research base on clinic setting but has been done in home
PCIT Goals

- Improve child compliance with adult requests
- Reduce disruptive behaviors
- Improve quality of parent child relationship

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Esther Deblinger, Anthony Mannarino, and Judith Cohen

*Center for Child and Family Health can provide training in this model.

The Evidence Base for TF-CBT

- Rated as 1- well supported by research evidence:
  - 8 RCTs
  - 4 with 6 month+ follow up
TF-CBT: Just the facts

- For traumatized children 3-18
- Research initially conducted on sexual trauma, now looking at traumatic grief, and other forms of trauma
- 12-20 one hour sessions
- Homework
- Parent and child seen separately and together
- Research base on clinic setting but has been done in home and schools

Primary Goals of TF-CBT

- Decrease in child PTSD, depression, and behavior problems
- Improved social competence compared to nonspecific treatment
- Improvement in parental distress, support & perceptions compared to non-specific treatment

Coping Power Program
John Lochman and Karen Wells
The Evidence Base for Coping Power Program
- Rated as 1 - well supported by research evidence:
  - 7 RCTs
  - 4 with 6 month+ follow up

Coping Power Program: Just the facts
- For children 8-14
- 34 one hour group sessions
- Homework
- Parent periodically seen separately (16 group sessions)

Primary Goals of Coping Power Program
- Better behavior at home and School
- Improved social competence
- Reduced substance use and delinquent behavior
The Evidence Base for MST
- Rated as 1 - well supported by research evidence:
  - 10 RCTs
  - All with 6 month+ follow up

MST: Just the facts
- For children 12-17 at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system.
- 3X/week-daily for 3-5 months
- Homework
- Parent and child seen together and separately
- Research base on home setting
Primary Goals of MST

- Reduce youth criminal activity
- Reduce other types of antisocial behavior
- Achieve these outcomes at a cost savings by decreasing rates of incarceration & out-of-home placements

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
Mandy Habib & Ruth DeRosa

*Center for Child and Family Health can provide training in this model.

The Evidence Base for SPARCS

- Not able to be rated by CEBC
- Several studies in process
SPARCS: Just the facts

- Group
- For adolescents between 12-19 years old
- 16 Sessions (60 minutes per session)
- No parent component

SPARCS Core Skills

- MAKE A LINK = communication & connecting with others
- Let 'M Go = problem-solving and creating meaning
- Distress Tolerance = coping more effectively in the moment
- Mindfulness = cultivating awareness

References