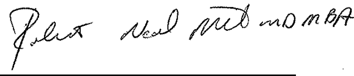
Origination Date: 5/21/09	Revision Date(s): 4/20/10
Developed By: Medical Criteria Committee	



Approved: **Robert Mills , MD** **Date:** 05/26/11

Description: Reactive Attachment Disorder of Infancy or Early Childhood (RAD)
RAD is characterized by markedly disturbed and developmentally inappropriate ways of relating socially in most contexts. It can take the form of a persistent failure to initiate or respond to most social interactions in a developmentally appropriate way (known as the "inhibited" form), or it can present itself as indiscriminate sociability, such as excessive familiarity with relative strangers (known as the "disinhibited form"). Children with reactive attachment disorder are presumed to have grossly disturbed internal models for relating to others, based largely on pathogenic care provided in infancy and early childhood. Consequently, they display markedly inappropriate behaviors in their attempts to gain warmth, approval, and social connectedness with others.

Criteria: (DSM-IV-TR)
Diagnostic criteria for Reactive Attachment Disorder of Infancy or Early Childhood is met if the patient satisfies the following:

A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2):
   (1) persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g. the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness.)
   (2) diffuse attachments as manifest by indiscriminant sociability with marked inability to exhibit appropriate selective attachments (e.g. excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures.)

B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in mental retardation) and does not meet criteria for a Pervasive Developmental Disorder.

C. Pathogenic care as evidenced by at least one of the following:

   (1) persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection.
   (2) persistent disregard of the child's physical needs
   (3) repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care).

D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbance of Criterion A began following the pathogenic care in Criterion C.)

Specify Type:
Inhibited Type: If Criterion A1 predominates the clinical presentation

Origination Date: 5/21/09	Revision Date(s): 4/20/10
Developed By: Medical Criteria Committee	

Disinhibited Type: If Criterion A2 predominates the clinical presentation

Assessment & Treatment Notes:

- Assessment for RAD requires evidence directly obtained from serial observations of the child interacting with his/her primary caregivers and with unfamiliar adults, as well careful review of history (if available). Typically, a full assessment takes 2-3 sessions.
- After assessment, any suspicion of previously unreported or current maltreatment requires reporting to the appropriate protective services agency.
- Assessment of the caregiver's attitudes toward and perceptions about the child should be addressed in the child's treatment plan.
- The diagnosis of RAD should be ruled out in any case where there is no evidence of parental neglect or abuse, or no evidence of repeated changes in primary caregiving.
- Children that are so aggressive as to be unmanageable in the family setting may require referral for a higher level of care.
- Dyadic therapy with caregiver and child is the preferred intervention strategy, in order to strengthen parenting skills and shape the child's social processing and interactive behavior. Individual therapy should only be considered as a limited, adjunctive service for dealing with behaviors that interfere with dyadic therapy.
- Co-occurring disruptive behavior disorders (Conduct Disorder, ODD) should be addressed separately in the treatment plan with appropriate treatment interventions.

Exclusions:

The following modalities have no empirical support, have been associated with serious harm including death, and are specifically excluded:

1. Interventions that promote regression for "reattachment"
2. Interventions designed to enhance attachment which involve physical restraint or coercion, including (but not limited to):
   a. therapeutic holding
   b. compression holding
   c. "reworking" of trauma
   d. rebirthing therapy

Information to be submitted with request:

1. Multi-axial diagnosis, symptoms, and functional impairment;
2. Relevant psychosocial and treatment history;
3. Alcohol and other drug use history;
4. Current medical status and relevant medical history;

5. Current medications;
6. Risk assessment;
7. Treatment plan; and
8. Specific goals for stabilization.

Criteria for Continued Treatment:

Continued authorization is indicated by **ALL** of the following:

1. The treatment plan establishes achievable recovery goals appropriate to the patient's symptoms, resources, and functioning.
2. Treatment is provided at the lowest level of intensity (including frequency and duration of outpatient sessions and duration of the treatment episode) necessary to maintain the patient's stability and achieve progress toward appropriate treatment goals. **Note**: *While extended outpatient visits (75-90 minutes) may be appropriate on occasion for crisis management, the routine use of extended outpatient visits lacks empirical support and is not covered. Special circumstances may be discussed with an ODS Behavioral Health Care Coordinator in advance.*
3. The treatment plan includes a realistic plan for termination and promotes the patient's ability to independently manage symptoms and resolve problems.

Plus **1 or more** of the following:

4. Continued measurable improvement in symptoms and/or functioning. Patients must demonstrate progress in treatment as evidenced by an increase in GAF score and improvement in behavioral outcome measures.

5. Continued progress toward development of skills to prevent relapse.

6. Treatment plan revision to address lack of progress. If no improvement is noted, the treatment plan should be modified to include the consideration of
   a. Need for medication evaluation
   b. Possibility of underlying Axis II condition
   c. Need for psychosocial interventions (i.e., support groups)
   d. Possibility of co-occurring conditions that need attention (e.g. medical conditions, substance abuse)
7. If there is a clear risk of deterioration with no further treatment, appropriate maintenance treatment is covered. If continued treatment is intended primarily to prevent deterioration, and significant improvement in symptoms is not expected, treatment should be provided at the least intensive level required to prevent deterioration. Periodic treatment plan updates may be required to track patient's progress.

If above criteria are met, the treatment plan should include a plan for terminating treatment.

Note*: Authorization for treatment will be based upon reasonable goals and expectations, and with the* ***explicit inclusion of caregiver participation in treatment****. Demonstration of*

Origination Date: 5/21/09	Revision Date(s): 4/20/10
Developed By: Medical Criteria Committee	

positive social interactions is considered the treatment goal. Prognosis for optimal functioning, which should be continually assessed, varies depending on a number of factors; however, access to an emotionally available attachment figure is critical for treatment to proceed.

If above criteria are met, the treatment plan should include a plan for completing treatment.

Termination Criteria:

Termination of continued authorization is indicated by **1 or more** of the following:

1. Caregiver is able to consistently provide an environment for socially appropriate interactions without the need for outside support.

2. Patient is not improving, despite amendments to the treatment plan (consider referral to another therapist or another form of treatment)

3. Patient has achieved a stable level of functioning and further treatment is not expected to produce significant improvement.

American Academy of Child & Adolescent Psychiatry (2003). Policy statement: Coercive interventions for reactive attachment disorder. Child Abuse and neglect Committee.

American Psychiatric Association (2002). Position statement: Reactive attachment disorder. Washington, DC: American Psychiatric Association.

Boris NW, Zeanah CH (2005). Practice parameters for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood. *Journal of American Academy of Child & Adolescent Psychiatry*; 44(11): 1206-19.

Schuengel, Carlom Oosterman, Mirjam, and Sterkenburgh, Paula.(2009). Children with dirstrupted attachement histories: Interventions and psychophysiological indices of effects. *Child and Adolescent Psychiatry and Mental Health,* 3(26). Available online at http://www.biomedcentral.com/.

Speltz, ML. (2002). Description, history, and critique of corrective attachment therapy. The APSAC Advisor, 14(3): 4-8.