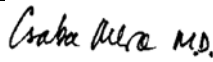


Origination Date:	Revision Date(s):
Developed By: Medical Criteria Committee	

Approved:



Date: 5/21/09

Csaba Mera, MD

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

Disinhibited Type: If Criterion A2 predominates the clinical presentation

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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:

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

Criteria for Continued Treatment:

The following criteria must be met for continued authorization:

- Treatment is provided at least intensive level (including frequency and duration of outpatient sessions) necessary to maintain the patient's stability and achieve progress toward appropriate treatment goals.

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AND

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

OR

- Continued progress toward development of skills to prevent relapse.

OR

- Treatment plan revision to address lack of progress. If no improvement is noted, the treatment plan should be modified to include the consideration of
 - Need for medication evaluation
 - Adjunctive treatment interventions for aggressive and/or oppositional behavior.
 - Change of treatment approach and/or treatment provider

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

- Caregiver is able to consistently provide an environment for socially appropriate interactions without the need for outside support.
or
- Patient is not improving, despite amendments to the treatment plan (consider referral to another therapist)
or
- Patient has achieved a stable level of functioning and further treatment is not expected to produce significant improvement.

References:

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,

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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.

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