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THE COMPLICATIONS WHEN WORKING WITH REACTIVE ATTACHMENT DISORDER

Susan Herberger

Regene Goens

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THE COMPLICATIONS WHEN WORKING WITH REACTIVE ATTACHMENT
DISORDER

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Regene Goens
Susan Herberger

May 2021

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Approved by:

Laurie Smith, Faculty Supervisor, Social Work

Armando Barragán, M.S.W. Research Coordinator

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ABSTRACT

This study aimed to identify the challenges professional care providers face when working with foster youth experiencing Reactive Attachment Disorder (RAD). Using a qualitative data approach, the researchers interviewed ten professional care providers and performed a thematic analysis of their responses regarding clients with RAD. The study found that professional care providers find this diagnosis to be rare and have a unique set of challenges. The challenges include identifying the disorder and its origins, working with clients who have extreme mood changes, the labeling and stigma that comes with the diagnosis, building rapport and trust, and the inconsistency the children experience. The participants were able to share unique experiences and specific challenges when working with this particular population. The researchers recommend policy changes to address issues of consistency, specialized training for professionals working with at risk communities, and for agencies (i.e. DCFS, schools) to work with one another. Although this study provides valuable information, it is important to remember that this study does not represent all professional care provider's thoughts on RAD.

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CHAPTER ONE

INTRODUCTION

Problem Formulation

Reactive Attachment Disorder (RAD) is a condition that impacts children and causes life-altering issues. Reactive Attachment Disorder is a disorder defined by the American Psychiatric Association (2013); noted by the following characteristics: (1) little to no reaction or seeking of comfort from their caregiver, (2) little to no social-emotional responses, minimal positive affect, or emotional episodes charged by irritation, sadness, or fear, (3) lack of social-emotional support from their caregiver, frequent changes of caregivers, or being institutionalized (i.e., foster care or group home). RAD is most commonly caused by childhood maltreatment, which is defined as physical abuse, sexual abuse, emotional abuse, neglect, and psychological abuse.

RAD is associated with the relationship a child develops with their caregiver within the first five years of life (Lang, et al., 2016). During the first five years of live, children are vulnerable and forming attachments to their caregiver and environment (Lang, et al., 2016) A child is more likely to develop RAD when the relationship with the caregiver is unstable, this can be due to parental substance use, poor parental mental and physical health, child abuse and neglect, or any circumstances where the childs physical and emotional needs are not met (Evans et al., 2018) .While RAD is not fully understood, children experiencing RAD often associate themselves with being worthless, unlovable,

and/or impotent (Pearce, 2009). The effects of RAD go far beyond home life; Ellis & Saadabadi (2020) suggests the effects of RAD include impacted classroom learning, poor self-esteem and self-image, a constant state of distress, and general mistrust in authority figures and peers. According to Kay and Green (2013), there is a connection between RAD and superficial relationships; meaning that emotional intimacy may never be accomplished. The relationships that are formed by an individual who experiences RAD tend to experience more strain on relationships going into adulthood.

According to the Diagnostic Statistical Manual (5th ed., 2013), the prevalence of RAD is unknown. The DSM-V also notes RAD is rare and seen mostly in foster youth who experienced abuse, severe neglect, and unstable caregivers. The DSM-V reports that this disorder occurs “in less than 10% of such children” (2013).

Social workers working with children who are experiencing RAD often face a unique set of barriers, the largest being rapport building. Murphy and Dillion (2015) discuss the importance of rapport building and identify rapport building as the trust and quality of relationships built with a client during the initial stages of treatment. Quality rapport building is easiest achieved with an individual who is innately trusting than one who innately is mistrusting. Evans et al. (2018) reports that rapport building may have unique challenges when working with children from diverse backgrounds including maltreatment, immigration, detachment from parents, and several other issues. Ahern et al. (2017) performed a study and

found that many social workers reported increased difficulty in building rapport with children who have been sexually exploited and abused. These children are at high risk of developing RAD.

The findings from this study will add to the knowledge regarding RAD and foster youth. This study focused on professional care providers (i.e. social workers, foster parents, case managers, therapists). Professional care providers often experience an unparalleled set of challenges when caring for children with RAD. The finding from this study will provide social work practice with a better understanding of how to approach rapport building with clients with RAD. These findings will also provide information regarding interventions to use with RAD clients to build rapport. The research question is: What challenges do professional care providers have toward helping foster children with RAD?

Purpose of Study

The purpose of this study was to understand the challenges faced by care providers when working with children in foster care who have RAD within the Inland Empire. RAD is most commonly found among children who have been neglected, abused, and/or separated from the primary caregiver (Dillon & Murphy, 2015). Thus, RAD is found in higher concentrations in foster care than in the general population (Follan, 2014). Children in foster care presenting with RAD face a multitude of issues in adolescence and adulthood. Care providers interfacing with these children face a unique set of challenges. There needs to be an understanding of these issues to aid the care providers and child alike.

The methodology for this study will be qualitative. The information will be gathered through interviews with professional care providers. This research method was selected because of the quality of an interview and the ability to analyze cases. Qualitative data always for a deeper view of why the interviewee answered in a particular fashion. Interviews also allow for further questioning, whereas survey data provides information without the opportunity to delve into the reasoning and understanding. Interviewing also allows for guidance and clarity on the interviewer's behalf.

Significance of The Project for Social Work

Understanding the challenges faced by the care providers and the outcomes and risks of RAD can further the knowledge in the social work field. Because there is little known about helping children with RAD, this research will create a conversation on how to work with these children. This research also speaks to the challenges of engaging children with RAD. Due to the nature of the disorder, it is especially challenged to provide services to this unique population. The results of this study will address the following question: What challenges do care providers have toward helping foster children with RAD? With the answers to this question, social workers involved with children who are experiencing RAD will have a premise for their practice. This research may offer a guide for those who are preparing to work with children with RAD in foster care. In addition, this research will open a conversation about how care providers working with this

population can address these issues or be prepared to aid children presenting with RAD.

Social work has limited research regarding care providers, RAD, and foster care. This unique intersection of diagnosis, population, and setting is under studied and requires more research to add to the wealth of social work knowledge. This research may not only be applicable to foster youth, but any provider working with clients presenting with RAD. This research may also benefit the supervisors of care providers in setting a roadmap to working with this very specific population.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter will briefly discuss the literature on RAD and the challenges professional caregivers can possibly face when working with population. This chapter will first define what RAD is, challenges children face with RAD, rapport building and trust amongst foster children with RAD, theory behind conceptualization and interventions/ treatments that can be used when working with a child with RAD.

Defining Reactive Attachment Disorder

RAD is a relatively new diagnosis and little research has been concluded on it (Stinehart, Scott & Barfield, 2012). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5,2013) defines RAD as a consistent pattern of inhibited and emotionally withdrawn behaviors of children towards adult caregivers as well as consistent social and emotional disturbance towards caregiver and/or peers. According to the DSM-5 children with RAD will tend to show symptoms of adamance about not seeking comfort or lack a response when comfort is presented and have no interest in engaging in social interaction. In addition, children with RAD emotional regulation are compromised and they often display negative emotions like fear, irritability, or sadness.

Although the exact prevalence of RAD diagnosis is unknown, researchers and clinicians have all come to the collective understanding that RAD is developed due maltreatment by the primary caregiver, which in turn causes the child to form an insecure attachment. Another element of RAD is insufficient care. The DSM-5 describes this as an experience of extreme inadequate care categorized by social neglect or deprivation from an adult caregiver, constant change in primary caregiver (i.e. foster care), and/or raised in a setting where secure attachment opportunities were limited.

According to the U.S Department of Health and Human Services in 2018, there were 4.1 million child maltreatment reports which involved over 7.5 million children. Due to these reports, children are removed from their homes and placed into foster homes. In the United States there are 437,283 children in foster care (U.S Department of Health and Human Services, 2018). Children in foster care are ten times more likely to have mental health challenges than children who are not in foster care (Gardenhire, Schleiden & Brown, 2109). In California, children in foster care only account for four percent of the population, but account for 41 percent of children's mental health claims (Gardenhire, Schleiden & Brown, 2019). There have been a number of studies done regarding child maltreatment and insecure attachment. Research studies have found that foster children with insecure attachment styles are more likely to have mental health challenges than their counterparts (Gardenhire, Schleiden & Brown, 2019).

Furthermore, children in foster care are ten times more likely to actually be diagnosed with a mental health illness (Gardenhire, Schleiden & Brown 2019). Being able to address insecure attachments in foster children (i.e. RAD), would greatly improve the mental and physical health of foster children. Children in the foster care system experienced trauma at alarming rates. According to AFCARS 2018 report, 62% of children in foster care have experienced neglect, research suggests these children are more likely to struggle with forming secure attachments.

Challenges Children Face with Reactive Attachment Disorder

When children experience a constant disruption in their attachment due to substantial neglect, and constant change in caregivers, it is known throughout literature that they are likely to experience profound emotional and behavioral problems in an array of context, including school, home life and in the community (Schwartz & Davis, 2006). Since children diagnosed with Reactive Attachment Disorder never experienced the reciprocity and security from a responsive and attuned primary caregiver (Schwartz & Davis, 2006) and instead grow up in chaotic and depriving environments, their ability to regulate their emotions and behaviors often appears out of control. These experiences have terrible implications when children enter school. The student-teacher relationship is very important for a child's success in school. With children struggling with attachment issues due to RAD school can be very problematic for them.

Floyd, Hester, Griffin, Golden & Canter (2008) claim that social and emotional school readiness is imperative for a smooth transition to kindergarten, and it is seen that children with RAD present with more teacher attention-seeking behaviors, over dependence on teachers as well as emotional dependency, and are more likely to exhibit proximity seeking behaviors. Children who have trouble paying attention, following teacher directions, getting along with others, or control negative emotions do significantly worse than their counterparts (Schwartz & David, 2006). Schwartz and Davis (2006) also claim that children with these challenges often are rejected by peers and given less positive feedback from their teacher. RAD does not only affect children's learning environment at school but as well as their environment at home.

Studies and literature supporting the experience of childcare workers, and primary caregivers working with children with RAD are not well documented (Follan, 2014), but with the limited amount of research that has been conducted it has captured both the children and the adult experience with RAD. Follan's (2014) study describes the experience and emotion that adoptive parents felt when raising a child with RAD. In that same study, the author accounts that parents felt a profound sense of being unprepared for the challenges that came from their child coming from a neglect filled background. Across the literature, common feelings of adults caring for children with RAD have been recorded as feelings of frustration, exhaustion, shock, surprise, and the feeling of caring a

burden. All of these feelings are created and connected to the fact the child was unable to make a secure attachment to them.

Childcare workers often express their concerns about the challenging time they have forming and maintaining relationships with children with RAD.

Oftentimes these same caregivers, teachers, and adoptive parents feel the same burden mentioned earlier. This might give reason to the lack of confidence they have in being able to completely understand and properly care for a child with RAD (Ferguson, Follan, Macinnes, Furnivall & Minnis, 2011).

The feelings of insecurity, self-doubt and inadequacy were illustrated in Follan's (2014) study where adoptive parents express feeling insecure, being assailed by unexpected emotions, and being committed to their children no matter what. Some parents in the author study expressed the difficulties of their children "pushing their buttons or testing them" and how it has caused them to experience the feeling of loss of control, disturbance, and vulnerability. A lot of these parents in the study mentioned how they have never experienced being pushed to uncomfortable levels of anger. And a lot of the parents just want their child to show them love and affection. Children with RAD are often time waiting for the next caregiver to come and start the whole attachment process over again, but parents in this study seem to want to commit to their children because they want to see them do great in life (Ferguson, Follan, Macinnes, Furnivall & Minnis, 2011).

Rapport and Trust

As mentioned above, a child's attachment affects all attachment associations and relationships in a child's life. The therapeutic alliance, (meaning the relationship between therapist and client) is one of the most crucial elements for success in therapy. Since children with RAD have difficulties trusting and building relationships with adults, research suggests that parallel experiences between therapist and other child workers (i.e., teachers, youth care workers, and social workers) share similar feelings of hopelessness and helplessness (Shea, 2015).

There has not been a lot of qualitative research on therapeutic relationships with children with RAD, but the research that is available has concluded that RAD can impact the effectiveness of treatment (Shea, 2015). However, the effectiveness of treatment was not hindered by the child, but the child's biological/ foster parents and the interagency lack of involvement with collaboration and communication (Shea, 2015). Therefore, Shea (2015) indicated the importance of really involving the child's caregiver and being able to collaborate and communicate with them. To fully grasp the implications of a therapeutic alliance with a child with RAD more qualitative research needs to be conducted, but these finds do correlate with the literature.

Theory Guiding Conceptualization

When understanding reactive attachment and all the possible challenges children face when living with this disorder it is important to take a look at John

Bowlby's attachment theory. Bowlby as well as Ainsworth developed this theory by studying the interaction between primary caregivers and young children (Hardy, 2007). They found that children were predisposed to form attachments in the first year of life (Gardenhire, Schleiden & Brown, 2019) and it is the responsibility of the adult to create an attentive and nurturing environment for the child. Attachment theory also suggests that attachments will be made regardless of the action of the adult primary caregiver (Hardy, 2007). Realizing children make an attachment regardless of treatment (Hardy, 2007). Ainsworth contributes to attachment in categorizing distinct levels of attachment.

There are four categories of attachment styles, secure attachment is the first. A child who displays a secure attachment to their primary caregiver can be observed being easily comforted by the primary caregiver, the child keeps appropriate proximal distance, often returning to their primary caregiver as a "secure base" to "refuel" (Lang et al., 2016). Research also suggests that children with secure attachments tend to get upset when their primary caregiver leaves but once they are rejoined the child appears to be comfortable again (Hardy, 2007). The same cannot be said for children who have an insecure attachment. Attachment theory describes insecure attachment in three different ways, the first being an avoidant attachment. When a child displays an avoidant insecure attachment, they present behaviors that are rejective (Hardy, 2007) these behaviors can look like, not keeping close proximity to the primary caregiver, and hiding emotions of distress and focus on exploration.

The next insecure attachment style is an ambivalent attachment, with an ambivalent insecure attachment the child does not take well to comfort when in distress, they can be seen trying to gain comfort but are met with rejection. The third form of insecure attachment is described as a disorganized insecure attachment. Children tend to have mixed feelings towards their primary caregiver. It can be seen in infants with a disorganized attachment that they will simultaneously reach for their caregiver but then turn away. This is due to feelings of confusion from the maltreatment of the primary caregiver (Hardy, 2007). Seeing as RAD's main component is the inability to have a secure attachment. Bowlby and Ainsworth's attachment theory correlate directly in understanding the challenges children face when diagnosed with this disorder.

Interventions and Treatment

There are mixed reviews on effectiveness of interventions and treatment throughout the literature regarding RAD. Much of treatment and interventions implemented for children with RAD are interventions used for children who identified abuse and or neglect (Floyd, Hester, Griffin, Golden & Canter, 2008). Another important element to consider when searching for effective interventions is the fact there are no standardized assessment measures to use in diagnosing RAD (Golden, 2009). Golden (2009) also posits that for RAD, traditional therapist and service are not helpful, improvements in behaviors were not followed by improvement in underlying cognitions, and adoption by nurturing parents did not change the outcome long-term.

On the contrary, other literature reviews regarding interventions and treatment for RAD favor quite a few different modalities. One being Dyadic developmental therapy, this is described as the attempt to stimulate the regulation process seen in healthy child-parent relationships (Steinhart, Scott & Barfield, 2012). Some other interventions that might be helpful for children with RAD include emotional coaching, trust based relational intervention, family therapy with an emphasis on Adlerian theory, and integrated play therapy, which has seen to be extremely beneficial for children with RAD (Gardenhire, Schleiden & Brown, 2019, Steinhart, Scott & Barfield, 2012). In order to begin the process of building a healthy bond, each intervention focuses on important factors to build attachment (Gardenhire, Schleiden, & Brown, 2019). These tools can help foster parents and children create a bond and hopefully minimize the frequencies of emotional and behavior challenges.

CHAPTER THREE

METHODS

Introduction

This study sought to understand the challenges professional caregivers face when working with foster children with RAD. This chapter explains how this study was conducted. The chapter discusses eight sections including study design, sampling, data collection and instruments, procedures, protection of human subjects, and data analysis.

Study Design

The purpose of this study was to explore the possible challenges that care providers have when helping foster children with RAD. RAD is a relatively new disorder to the DSM-5 and very little research has been conducted with this population. Since there is so little research about how to work with and help children with RAD. This study took a qualitative approach through interviews with care providers who have worked in this population.

Using a qualitative approach, with a focus on personal interviews, has both strengths and limitations. One strength was using interviews as first-hand individual experiences. The interviewees had the opportunity to provide in-depth answers. Since the study was interested in exploring care providers' challenges when working with RAD their perspective is completely accounted for.

One limitation to using this approach is the lack of anonymity. Unlike a survey or a questionnaire form, in an interview the interviewee may monitor themselves and what they say because it can be traced back to them. When participants fill out an item like a survey, the fear of saying wrong is naturally at a minimal due to the nature of the layout. The study is designed to explore challenges with RAD so, reassuring participants of confidentiality will hopefully account for this. Additionally, this study had participants that are all in the southern California area. Therefore, it must be noted that this particular group does not represent any geographic locations. Finally, the group of participants is only ten people. While their experiences are valuable, they are not representative of the entire care provider population.

Data Collection and Instruments

This study was focused on collecting data through interviews regarding care providers experiences and challenges with RAD and the challenges presented when working with RAD foster youth. The interviewees will be found via snowball methods. The researchers began with the researchers reaching out to professional care providers in their immediate networks (such as social workers, case managers, therapists, etc.) and asking those who have been interviewed to recommend interviewees from their immediate networks. This data was collected via Zoom. The interviews were recorded and transcribed via Zoom. The researchers used an interview guide (see Appendix A).

Demographic data was not gathered for this study as demographic characteristics did not impact the study. The interviewees were only asked to describe their experience. Zoom automated an ID number unique to each participant. The interview guide consists of questions for the interviewer to ask participants. The interview guide has fifteen questions which must be asked in addition to any follow up questions which might develop as the interview moves forward. The interview guide doubles as a note template. The interviews are expected to have a duration of forty-five minutes to one hour.

Sampling

For this study, the researchers used convenience sampling. The interviewees were solicited through the researcher's networks such as current and previous field placements. The interviewees are required to meet the following criteria: (1) must be considered a professional care provider to foster youth (i.e. social worker, therapists, case manager), (2) must have recent experience with foster youth (within the past ten years), (3) experience should be in southern California, (4) the interviewee should have had the experience of no less than two years ago. The reasoning for these criteria is to ensure fresh, relevant, and substantial data. The reasoning for southern California is to keep the pool of data in a similar area.

The sample size was ten interviewees. This allowed for diversity in the interviews without overwhelming the researchers. This sample of ten also accounted for interviewees who could not recall or are unable to convey their

experience with RAD. Due to the rarity of RAD, it may be more challenging to gain data and find interviewees who have seen RAD in a foster care setting.

Procedures

The goal of this study was to obtain meaningful data by interviewing professional care providers. These care providers could range from social workers in family and child services, to group home care providers, to case managers, to other child welfare workers. The interviewees were solicited through the networks of the researchers. For example, the researchers asked colleagues at field placements, colleagues from past field placements and employment, and reach out to community agencies.

Due to the restrictions that the COVID-19 pandemic has placed in society, all interviews were conducted via Zoom. These interviews lasted no longer than forty minutes and were designed to be semi structured. The interviewer asked all fifteen questions and also asked follow up questions as needed. The interview felt natural and fluid.

Protection of Human Subjects

Individuals met in an online platform. The meetings done via Zoom were recorded for the researchers to review. Zoom also allowed for transcription of the data. The researchers provided the interviewees with informed consent (Appendix B) as well as a guide to protecting their identity. The researchers did not publish any identifying information including, but not limited to, children's

names, interviewees' names, or agency names. The researchers provided a debrief to the interviewee which will review the purpose of the study, the limits of confidentiality, the school the researchers who are performing the study, and any other necessary information. The research protocol was approved as exempt by the California State University, San Bernardino Institutional Review Board.

Data Analysis

The type of analysis used is referred to as thematic analysis. After the collection of the data, the researchers reviewed the transcripts and recordings, obtained via Zoom, of the interviews. Each interviewee was provided a unique identification number used during the analysis as well as the writing of the research. The researchers also noted paralinguistic cues as well as nonverbal communication when applicable.

The varying statements were categorized by topic, themes, presenting issues, and type of agencies. This categorizing aided the researchers in synthesizing the data and organizing the thoughts and ideas of the interviewees. The researchers read over the data several times to ensure the data was in the correct category. The statements were stored in a Microsoft word document and coded according to the aforementioned categories.

Summary

In summary, the purpose of this study was to explore the experiences of care providers with foster youth who have experienced RAD. Through interviews

with care providers who have recent experience with foster youth, the researchers found additional information and insight to RAD. The interviewees were interviewed via Zoom. The researchers sifted through the interview transcripts and notes to identify major themes. Lastly, it was extremely important to protect the rights of the interviewees, their cases, and their agencies.

CHAPTER FOUR

RESULTS

Introduction

The aim of the study was to find the challenges faced by professional care providers when working with foster youth experiencing RAD as it is defined in the Diagnostic Statistical Manual, fifth addition (DSM-V). The participants were interviewed by the researchers in a semi structured fashion. The researchers used thematic content analysis to identify the major themes and consistencies between the interviews. The following chapter will provide a sample background, divide the themes into twelve categories, provide results in direct relation to the research question, and summarize the findings.

Sample Background

There was a total of 10 participants. All participants were social workers, eight of which were licensed clinical social workers (LCSW). The participants were all seasoned social workers with a minimum of four years' experience. The collective employment history of the participants ranged from department of child and family services, private practice, family court mediation, juvenile dependency court, group homes, residential treatment, adoption agencies, department of behavioral health, wrap around services, nonprofit sector, and school social work.

The range of tasks carried out by the participants includes case management, individual and group therapy, supervisory tasks, assessments, diagnosing, freelance social work, facilitators for family services, and family mediation. Of the ten participants, all of the participants were familiar with the DSM. Most participants had more experience with the DSMIV-TR¹ than with the DSMV. Five of ten participants had extensive experience with diagnosing, while others used the DSM to inform treatment plans or provided provisional diagnoses. None of the participants were unfamiliar with the DSM.

Presentation of Findings

This section will be comprised of eleven subsections. The subsections are Familiarity with Diagnosis, Presence and Commonality, Challenges, Interventions, Behaviors, Goals, Improving Practices, Resources, Origins, Management of Disorder, Corrective attachment experiences, and Additional Information.

Familiarity with Diagnosis

All participants had knowledge of RAD. Some participants were only familiar with RAD from academia. Three of the participants had attended specialized trainings for RAD. Eight of the participants mentioned being familiar with attachment issues as they are presented by Bowlby and Ainsworth within

¹ The DSMIV-TR is the Fourth edition of the Diagnostic and Statistical Manual of Mental Disorders. This addition specifically changed split Reactive Attachment Disorder into two separate diagnosis, Reactive Attachment Disorder and Disinhibited Social Engagement Disorder.

Attachment Theory. Two participants discussed the importance of understanding systems theory as a functionality of attachment.

Presence and Commonality

The consensus of RAD is that is exceedingly rare and challenging to diagnose due to the nature of the diagnosis. Eight participants noted the increased likelihood of a RAD in foster youth due to adverse childhood events (i.e., trauma, abuse, neglect). Four of the participants had actual cases with true RAD. However, all of the participants either had first hand experience with RAD or had a colleague who had a case with RAD. Six participants mentioned that during assessment they would assess for attachment issues in general to better understand the client. All participants noted that general attachment issues are significantly more common than true RAD.

Challenges

The participants unanimously reported that rapport building and trust are extremely challenging when working with children experiencing RAD. Seven of the participants discussed the importance of consistency in both the clinical and familial settings. Three participants described the challenge of not taking things personally when that is not intended in such a way. Four participants expressed the challenges of working with a child who can be aggressive, manipulative, or violent. Five participants indicated that establishing boundaries and structure are exceedingly challenging when working with RAD. Some other challenges presented in the interviews consisted of diagnosis is missed due to the child's

age, lack of prevention, identifying the origin of the disorder, reading a child's affect, and the child's inability to follow direction.

Interventions

The participants were asked to describe interventions they have used or have heard of being used when working with RAD or severe attachment issues. All participants noted the importance of long-term therapy, identifying boundaries, and clinician follow through. Two participants specifically addressed interventions that involve changing the therapeutic setting by going for walks with the client. Six participants reported play and art therapy as interventions to build trust and communicate with less invasive means. Five participants stressed the importance of collaborating with the family and providing psychoeducation to parents so they may create the necessary environment. Some additional interventions mentioned were the use of humor, modeling, grounding, and breathing exercises. Two participants reported that medication may be used to mitigate the intense mood shifts the child may experience and create an opportunity to provide services with less of the mood shifts.

Behaviors

All participants were unanimous regarding majority of the behaviors of children experiencing RAD. Those behaviors include: (1) not seeking approval/attention, (2) poor boundaries, (3) poor emotional regulation, (4) low social skills, (5) negative self-talk and self-sabotage, (6) rapid changes in mood, and (7) disinterest in surroundings. According to some of the participants, other

behaviors reflecting RAD include frequent trouble in school, being label as a “bad kid,” and lack of eye contact.

Treatment Goals

The ten participants were asked to discuss the goals for children and families experiencing RAD. The entire group of participants regarded coping skill development, boundary setting, and improving communication as treatment goals for this population and their families. Additionally, eight participants discussed the importance of family involvement and family psychoeducation to improve the home environment. Three participants described the absolute need for family involvement due to the young age of children when the diagnosis is given.

Improving Practices

The participants unanimously agreed that providers working with this population need to participate in trauma informed care practice, training specifically on RAD, and trainings specifically regarding foster youth.

Resources

When asked about the resources that should be made available for families and children experiencing RAD the following resources were discussed: (1) support groups for parents, (2) wrap around services, (3) case management, (4) individual therapy, and (5) community-based resources. Two participants went into great detail regarding the need for prevention. The participants indicated that it is important for parents of young children to receive services as

early as possible (or during pregnancy). Some of the prevention services, according to participants, could be mommy toddler circles, parental support groups, and community centers for families.

Origins

Generally, participants discussed child neglect, abuse, and unstable environments. Seven participants indicated that trauma could be a cause of RAD. Five participants discussed the mental and physical health of the parent, specifically substance use, mental health diagnoses, and trauma. One participant discussed how RAD can begin in utero if the mother is not stable, as this is the first home of the child.

Management of Disorder

All participants noted RAD cannot be cured but it can be overcome and managed. Three participants discussed how the disorder is something the child will carry with them and must learn how to cope. The skills mentioned by the participants include management of emotions, management of symptoms, and creating meaningful attachments.

Corrective Attachment Experiences

When participants discussed corrective attachment experiences, there was a consensus that the corrective attachment experiences are vital to the recovery of a child experiencing RAD. Seven participants stated it is the best form of treatment for this population. Two participants indicated corrective

attachment experiences are a means to end generational abuse, neglect, and trauma.

Additional Information

The participants were given the opportunity to provide additional information or feedback regarding RAD. The responses include avoiding labeling the child, treat the child fairly, refrain from stigmatization, and to be transparent with the child and family.

Summary of Findings

The research question, “what are the challenges professional care providers face when working with foster youth experiencing RAD?” was in fact answered in this study. The participants presented a wide, detailed array of responses which were analyzed and combined to create a cohesive answer to this question. The participants also provided insight to other aspects of attachment issues and challenges that providers face. Unintentionally, all of the participants are social workers. Thus the answers are truly from a social workers view, not a physician, psychiatrist, psychologist, or other disciplines.

Overall, the participants provided clear ideas regarding their work and involvement with foster youth experiencing RAD. The various themes that presented in the research include rarity/commonality, need for resources, challenging behaviors, rapport and trust building, treatment goals, causes and origins of the disorder, and the importance of early intervention. The participants each discussed how challenging this population is due to the nature of the

disorder, age, origins, need for intensive family support and involvement, and the behaviors that present. In other words, treatment for RAD requires a combination of treatment modalities and interventions that may not be available to all clients, families, and or clinicians.

CHAPTER FIVE

DISCUSSION

Introduction

This study examined what challenges professional care providers have toward helping foster children with RAD. This chapter will briefly review the significant results of the study, discuss supporting findings through literature, identify unanticipated results, discuss limitations, and present practice, policy and research implications.

The participants provided their understanding of challenges faced when trying to help a child with RAD. All participants shared their challenges and different kinds of interventions that help combat their challenges when working with a child with RAD. Additionally all participants shared how important it is for children with RAD to have corrective attachment experiences. As participants shared their challenges and experiences when working with children with RAD it became evident that the participant shared common challenges when working with foster children with RAD. The themes that emerged when discussing challenges care providers face when working with a child with RAD were building rapport and instilling trust into the child, the lack of knowledge the child and the child's family has with reactive attachment, the child's symptoms, and the inconsistency with family dynamics.

Discussion

Building Rapport and Trust

When discussing challenges care providers can face when working with foster children with RAD, building rapport and trust was a reoccurring theme. Interestingly, this theme aligns with the literature surrounding RAD. As mentioned above, children with RAD have difficulties trusting and building relationships with adults (Shea, 2015). This finding is similar to several other studies that discuss RAD in foster children. Schwartz and Davis posit that Children will enter relationships with others based on these early experiences, and if these attachment relationships have been characterized by abuse and neglect, these future relationships will often reflect the problematic nature of their early attachments.” This highlights the challenge of building rapport and creating a trustworthy relationship, since these children have been involved in maladaptive relationships with adults children with RAD are extremely hesitant to create and receive a bond with any adult.

Lack of Knowledge

Going through the literature and analyzing our participant data we saw an overwhelming pattern of lack of knowledge from the parent and the child regarding what RAD is and how to manage the disorder with the child and the family. Our participant’s experiences with children with RAD and their family, and their lack of complete understanding of RAD aligns similarly to what is in the literature. Follan 2013 posits that “despite preparation, assessments and training,

support classes, adoption screening, background checks, health and psychological strengths and weaknesses” each participant experienced a profound sense of unpreparedness for the challenges that the adopted child presented with. Our participants described having to emphasize family involvement more than any other child that is not diagnosed with RAD. Our participants described having to do interventions that help the parent-child relationship heal and recreate meaningful connection. Caring for a child with RAD can come with a lot of heaps and challenges, so foster families need to be prepared as best they can on the history of the child and come with the understanding of what RAD actually is.

Inconsistency

As explained above children create secure attachments through parental nurturing and a stable environment. Children start to create insecure attachments when they are in chaotic, hostile, unstable environments and when they are receiving proper nurturing from their primary caregiver. Our participants suggested that family inconsistency was another challenge faced when working with a foster child with RAD. RAD is a relational disorder, meaning this disorder is essentially created due to failed relationship bonds in a child's first few years of life. Our participants suggested that most of the work and interventions need to be done at home with the family consistently, and that family support services would help facilitate consistency for the whole family. Elements that align with consistent family involvement to help manage symptoms of RAD or lack of

involvement can be found all throughout the literature. For example, Shea (2015) claims treatment of RAD was not hindered by the child itself but by the lack of collaboration with the family and outside support services.

Behaviors

The last theme that was pertinent in our study was the challenging behavior a child with RAD can present with. Collectively all of our participants described how challenging it can be to manage a child's with RAD behavior. The behaviors of a child with RAD often go hand and hand with the symptoms. Follan's (2013) study puts forth that "behaviors of children with a diagnosis of RAD gave rise to a constellation of emotions" (p.1081). Our participants described these behaviors having poor boundary issues, emotionally unstable, detached, disinterested in surroundings, low social skills and at times self-sabotaging. In that same study by Follan (2013) claims "that the constant need for children diagnosed with RAD to continuously test their adoptive parents' commitment can be exhausting and emotionally draining" (p.1082). This study parallels with our findings that the behaviors a child diagnosed with RAD can present with is extremely challenging.

Limitations

Limitations of this current study include small sample size and method of data collection used. Due to time constraints and the COVID-19 pandemic only a limited number of participants were able to volunteer and complete the interview process. Additionally, all participants worked in Southern California all relatively

in the same area. Also, participants were generated through snowball sampling, as researcher we had limited control on who was being sampled due to that sampling bias naturally comes into play. Small sample size and participants limit the ability to truly generalize our findings since the sample size did not include participants outside of participants close relational circles. Allowing other professionals from other districts outside of our participants circle or Southern California could have yielded more generalized results.

Recommendations for Social Work Practice, Policy, and Research

From this research, the researchers have formed five recommendations for social work practice and policy as well as one recommendation for further research. The recommendations range from training, stabilizing environments, policy changes, preventative care, and the need for more research. The recommendations were developed based on the results of the study.

The first recommendation is for professional care providers to receive specialized training on RAD when working in high-risk populations. Several participants noted that their only knowledge of RAD was obtained in an academic setting. Providing specialized training to professionals provides a platform for conversation, opportunity to learn, and can potentially fill in the unknowns in terms of RAD. The researchers found that the participants unanimously reported the need for more RAD training. Because the diagnosis is specialized, the general professional care provider knows little to nothing about the diagnosis. Having specialized training for professionals working with at risk populations and

with children (i.e. foster care, institutionalized children, school therapists). These trainings would help professional care providers know the symptoms and assess accordingly. Trainings regarding RAD would give professional care providers the opportunity to learn new interventions and rapport building techniques.

The second recommendation is for agencies (i.e. DCFS, schools, therapists) to work together to build a stable and consistent environment. Stability and consistency were major themes discovered by the researchers. The consensus of the participants was that stability and consistency are vital to the treatment of a child with experiencing RAD. Several participants discussed how the child welfare system may have additional negative ramifications on children; for example, a child who has multiple placements over a short amount of time. Agencies ought to be more connected to the families, schools, and DCFS to ensure that the child is getting consistency across all boards.

Thirdly, policy should be changed to protect foster children from being further harmed by the system. This recommendation is in relation to the aforementioned recommendation. The child welfare system saves many children, but can have negative ramifications on the children served. Policy is a means by which there can be improvements in current child welfare codes. Creating policies and funding around child welfare would provide support to children who are a part of the foster care system.

The fourth recommendation is for more preventative programs in communities to support families with young children. One participant reported the

need for more preventative programs. There is a need for macrolevel interventions to implement programs to support families in at risk communities (i.e. impoverished communities). Tailoring programs to low income families, families experiencing trauma, young parents, and substance using parents would create a safety net to hopefully reach families before more trauma develops. These types of supports should be referred to families through doctors' offices, hospitals, schools, planned parenthood, head start programs, DCFS, and any other community programs.

Finally, the researchers recommend that further research must be conducted to learn more about RAD and the associated factors. Researchers should interview politicians, child welfare agencies, school therapists, and other appropriate candidates. There is a need for research regarding interventions, policy changes, and program implementation.

Conclusion

This study aimed to identify the challenges professional care providers face when working with foster youth experiencing RAD. Using a qualitative data approach, the researchers interviewed ten professional care providers and performed a thematic analysis. The study found that professional care providers find this diagnosis to be rare and have a unique set of challenges. The challenges include identifying the disorder and its origins, working with clients who have extreme mood changes, the labeling and stigma that comes with the diagnosis, building rapport and trust, and the inconsistency the children

experience. The participants were able to share unique experiences and specific challenges when working with this particular population. Although this study provides valuable information, it is important to remember that this study does not represent all professional care providers.

APPENDIX A
INTERVIEW GUIDE

Interview Guide & Notes Template

Created by
Regene Goens
Susan Herberger

1. Please describe your experience with foster youth
2. Please describe your familiarity with the DSM (include discussion of edition, diagnosing)
3. Are you familiar with reactive attachment disorder? If so, describe familiarity
4. Have you seen reactive attachment disorder symptoms present in a foster child during your work experience? If yes, what were the challenges faced?
5. Do you know anyone who has worked with foster youth experiencing reactive attachment disorder? What do you know of their challenges?
6. What are some of the interventions you have used (or heard of being used) with reactive attachment disorder? Did they work well? What were the issues?
7. What behaviors in a child lead you to conclude they have reactive attachment disorder?
8. How are children with reactive attachment disorder different than others?
9. How do you work differently with children with reactive attachment disorder?
10. What are your goals for families with children with reactive attachment disorder?
11. How common is reactive attachment disorder in your experience?
12. What type of training could be done to better serve clients with reactive attachment disorder?
13. What types of resources should be available to clients with reactive attachment disorder?
14. What do you think causes reactive attachment disorder?
15. How can reactive attachment disorder be overcome or cured?

APPENDIX B
INFORMED CONSENT

INFORMED CONSENT

The study in which you are asked to participate is designed to explore the possible challenges that care providers have when helping foster children with reactive attachment disorder. The study is being conducted by Regene Goens and Susan Herberger, gReactive Attachment Disorderuate students, under the supervision of Dr. Laurie Smith, Assistant Professor in the School of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board at CSUSB.

PURPOSE: The purpose of the study is to explore the possible challenges that care providers have when helping foster children with reactive attachment disorder.

DESCRIPTION: Participants will be asked questions on their familiarity with REACTIVE ATTACHMENT DISORDER, Signs, symptoms, treatment and challenges with REACTIVE ATTACHMENT DISORDER, their experience with foster youth, and some demographics.

PARTICIPATION: Your participation in the study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY: Your responses will remain confidential and data will be reported in group form only.

DURATION: It will take approximately one hour to complete the interview.

RISKS: Although not anticipated, there may be some discomfort in answering some of the questions. You are not required to answer and can skip the question or end your participation.

BENEFITS: There will not be any direct benefits to the participants. However, findings from the study will contribute to our knowledge in this area of research.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Barragán at (909) 537-3837.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database

(<http://scholarworks.lib.csusb.edu/>) at California State University, San Bernardino after July 2021.

APPENDIX C
INSTITUTIONAL REVIEW BOARD APPROVAL LETTER



January 21, 2021

CSUSB INSTITUTIONAL REVIEW BOARD

Administrative/Exempt Review Determination Status: Determined Exempt
IRB-FY2021-55

Laurie Smith Regene Goens, Susan Herberger CSBS - Social Work
California State University, San Bernardino 5500 University Parkway

San Bernardino, California 92407

Dear Laurie Smith Regene Goens, Susan Herberger:

Your application to use human subjects, titled "Reactive attachment" has been reviewed and determined exempt by the Chair of the Institutional Review Board (IRB) of CSU, San Bernardino. An exempt determination means your study had met the federal requirements for exempt status under 45 CFR 46.104. The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk and benefits of the study to ensure the protection of human participants. Important Note: This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses due to the COVID-19 pandemic. Visit the Office of Academic Research website for more information at <https://www.csusb.edu/academic-research>.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission webpage. Failure to notify the IRB of the following requirements may result in disciplinary action. The Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have completed your study.

Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.

Submit a protocol modification (change) if any changes (no matter how minor) are

proposed in your study for review and approval by the IRB before being implemented in your study.

Notify the IRB within 5 days of any unanticipated or adverse events are experienced by subjects during your research.

Submit a study closure through the Cayuse IRB submission system once your study has ended.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval number IRB-FY2021-55 in all correspondence. Any complaints you receive from participants and/or others related to your research may be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

Nicole Dabbs

Nicole Dabbs, Ph.D., IRB Chair CSUSB Institutional Review Board

ND/MG

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ASSIGNED RESPONSIBILITIES

Both researchers are responsible for the written proposal. Susan Herberger wrote chapter one, Regene Goens wrote chapter two, and both researchers wrote chapter three. Susan Herberger formatted the proposal and completed the edits. Regene Goens complied the IRB application. Susan Herberger wrote the interview. Regene Goens completed the informed consent. Both researchers are responsible for recruiting interviewees. Both researchers conducted interviews, five each. Susan Herberger wrote chapter four. Regene Goens wrote chapter five introduction, discussion, and limitations. Susan Herberger wrote chapter five recommendations and conclusion.