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ATTACHMENT AND REACTIVE ATTACHMENT DISORDER©

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We have so much to tell you about *attachment*, the child's *Internal Working Model of the World, attachment cycles, co-regulation, attachment styles, attachment wounds, and Reactive Attachment Disorder*. We hope this article will help parents understand child behavior in a new way. Any wounded attachment is an indicator therapy may be helpful. This may be a long article, it is filled with information for parents, especially when you have adopted children. **This is a 15-minute read and resource document, but rewarding for parents, grand-parents, clinicians, and all of us – we all had attachments and may want to understand them better**.

You may also want to read our article *From the Mind of a Child With Reactive Attachment Disorder*.

What everyone should know about attachment is in the first half. The part about Reactive Attachment may interest adoptive parents and grandparents and sblings and parents who have come back to their children after their own recovery; we put that in the second half of the article.

Introduction

Human beings are hard wired for social attachment. Our earliest attachment figures are our immediate caregivers. Children need those caregivers to provide safety and emotional security. The essence of the process we call *attachment* is a feeling of being in proximity to someone who makes you feel safe. The attachment process in infancy culminates in the second half of the first year when the child becomes more attached to the main caregiver(s) who takes care of that child and provides for his or her safety.

That is the beginning of a process that is lifelong. Even adults create attachment relationships. However, those **adult attachment relationships are based upon the quality of the *earliest* attachment relationships**. As we will explain, *breaches or wounds in early attachment affect the ability of people to attach throughout the rest of their lifetimes*. And yet, at the same time, *repair of the attachment system is sometimes still possible through a healthy positive, safe later relationship*.

RAD. Because of the experience of emotional and physical neglect in early childhood, one group of children are so wounded in their attachments that they develop a psychiatric disorder we call *Reactive Attachment Disorder*. These children seem to have a turned off or inactivated the attachment system and so they never fully attach. This affects the nature of their social behavior for the rest of their lives. Again, some repair is possible under certain circumstances, although the treatments for reactive attachment are still in a very early stage of development.

Attachment

Attachment is the closely-connected emotional relationship between a child and his or her primary caregiver(s). *Effective attachment* comes from consistent care of the child's **basic** *and* **emotional** needs for safety and security from earliest infancy through around age five. Attachment is critically important -- it involves some of our most basic emotional capabilities that ordinarily develop in a securely attached child:

- basic trust in others
- the sense of living in a dependable and predictable world
- sense of self-worth, identity, and being special and worthwhile
- capacity to regulate the sense-of-self
- capacity for effective autonomy
- capacity to regulate emotions, emotional arousal, and calming or soothing after a disturbance in emotions.

Attachment is a core element in our basic *schemas* (deeply held ideas) for understanding the world and our place and value in it. We refer to that as the child's *Internal Working Model of the World*.

Attachment Cycles in Earliest Childhood

Attachment in the 1st year builds Basic Trust. *The Attachment Cycle:* Infants are responsive to the face and actions of caregivers almost immediately! We are genetically programmed to respond to those who keep us warm, protected, pick us up, in whose arms

we sleep. The cycle is repeated many times every day. All these loving behaviors lead the child to learn invaluable *schemas* for understanding the world, such as to trust the caregiver with his or her needs; to expect the world to provide comfort, safety, and gratification; to be self-reliant in getting needs met; and to expect the presence of others to be potentially comforting. Because of rapid brain development in this period, **brain structure incorporates this view of reality**. (Of course, brain structure also incorporates a representational model of the world when caregivers do not consistently meet needs.) The 'good enough' caregiver – no one can be or needs to be perfect -- satisfies needs and also lovingly *comforts* the child and *also confirms* the child's worth with loving words and loving looks. So, therefore, proximity and connection is associated with pleasure, love, *and* closeness.

In one experiment, mother was to have a flat, impassive face no matter what the child was doing. Children became extremely distressed and worked to force the mother to react. The need for constant confirmation from the caregiver is salient thoughout our earlier years, and, to some extent, the need for all kinds of validation stays with us – for we are social, attached beings. As you will see, *the way we experience early validation and safety affects how we seek it ever after*.

Co-regulation. Another important cycle is called *co-regulation*. The infant knows pleasure. But it also know distress, misery, and crying. It cries so instantly. It has to learn how to

regulate its emotional and bodily states. It does so through the responses of others. A calming, soothing parent with a smiling face and gentle voice leads the child to internalize regulation of its emotions. They are doing this as a pair, hence CO-regulation. You can imagine how a distressed, frustrated, depressed parent may not help the child co-regulate optimally. Don't despair as there are opportunities later to help the child develop healthier self-regulation.

Attachment in the 2nd year builds Autonomy. *The Attachment Cycle:* A child now can toddle around and walk. So, its personal environment expands. As the child explores the environment, it checks where its caregiver may be. The child gets a little bit away and checks the caregiver is still there, that it is safe. If a stranger appears, the child scurries back to the safe base. The caregiver encourages autonomous exploration of the environment and play. The caregiver reinforces by providing safety an encouragement to the child meets the need to imitate parents, explore, and try new experiences. The parents keeps the child safe, but let the child learn what he or she can do. That contributes to forming an *identity*. You can see how autonomy in the environment, self-worth as a learner in the world, and safety all become part of our self-esteem and our sense of self.

Attachment & the Brain Shore, Van der Kolk, & other brain, attachment, & trauma researchers suggest Attachment interactions do some of the crucial neurobiological work of childhood.

1. The brain overproduces dendritic *connections* between cells; caregiver-child interaction is critical to developing permanent brain pathways among these *connections* – for ***interpersonal relations, positive emotions, security, pairing a sense of reward-pleasure with human interaction, and self-control*** -- while pruning away connections which are not needed for a particular environment and set of relationships. So, Attachment behavior is a consequence of how the brain becomes wired as a result of culturally-mediated parental responses.
2. In addition, the right hemisphere is dominant in the early years, during which the left (verbal) brain develops. Positive emotions (from successful attachment in early life) lead to ***enjoyable recognition of mother's face, positive emotions of interest/excitement and enjoyment/joy***. These emotional experiences enhance dendritic growth and emotional regulation via right hemisphere-prefrontal-brain stem circuits necessary for self-control and good judgment. Positive experiences release endogenous opioids (pain-pleasure mediators) and catecholamines (dopamine-serotonin) and other mood & WELL-BEING regulators), enhance left hemisphere (language) development, and promote expansion of the interconnecting corpus callosum (for behavioral integration).
3. When interaction arouses positive emotions, the child learns to ***down-regulate distress, maintain excitement and joy*** at optimal levels, associate caregivers with soothing, and develop self-regulatory soothing.
4. During the second year, parents provide optimal amounts of inhibition to teach ***regulation of exploratory behavior to avoid danger and adapt to social values.*** In contrast, excessive shaming and interruption of behavior reduces endogenous opioids and dopamine. Traumatic attachment experiences are associated with stress hormones (fight-flight reactions), hippocampal atrophy (lowered attention, memory, and identity). The left hemisphere Broca's area (speech) is inhibited when trauma memories are aroused. Physical or sexual abuse and neglect causes an under-developed corpus callosum. Then, left hemisphere is not adequately engaged in processing the trauma, in developing a narrative story, in developing *schemas* of positive memories. Or the left hemisphere can come on line without right hemisphere activation (i.e., without positive affect) and the positive memories are weak, underdeveloped, unemotional (no joy).

A child wants some object or to engage in an activity, such as touching the TV, having cookies, etc., which provokes limit-setting by others. The caregiver says or indicates *yes* or *no* or gives appropriately firm but caring responses limiting the child. The child may rage at limits, but learns to accept the limits. *Children learn to believe that impulses of self and others can be controlled*, to understand that fantasies of harm and danger are unlikely to come true, that a parent will comfort its injuries, to manage anger and fear, and basic moral thinking (concepts of right and wrong, rules). *A child whose autonomy is confirmed, but gently directed, will expand his or her sense of self-worth*.

Attachment Wounds

Breakup of a love relationship in adolescence leads to heartbreak. The way a broken heart feels is a type of attachment wound.

Attachment Wounds are *deep emotional injuries* when attachment needs are not met during critical developmental periods, particularly in childhood. The consequences of such wounds can profoundly affect a child's emotional, cognitive, and social development.

Wounded attachment begins with extended separation from caregivers, traumatic loss of caregiver, perhaps loss of a family member leading caregiver to be withdrawn from the child, caregiver mental or physical illness resulting in lack of caretaking, abuse, neglect, or other disruption in the attachment relationship. Wounds are more common than RAD, which comes from extreme attachment wounds and occurs in one or two in 100 children

For example, children with attachment wounds may struggle with feelings of insecurity, low self-esteem, and mistrust toward others. They might have difficulty forming close relationships, often oscillating between seeking excessive reassurance and pushing others away. Such children may also exhibit heightened sensitivity to rejection or abandonment, interpreting benign actions as threats to their relationships.

Behaviorally, wounds may lead to attachment-disrupted acts, such as aggression, withdrawal, volatile emotions, defiance, poor self-control of impulses, or clinging. Those reflect the child's internal turmoil and insecurity. *In adulthood*, wounds affect the ability to establish and maintain healthy relationships, impacting mental health, and even shaping the parenting styles of that adult. Wounds potentially perpetuate a cycle of insecure attachment in the next generation.

Therapists detect attachment wounds in the client's history and use the *therapeutic relationship* and a variety of interventions in order to help with repair and recovery.

Attachment Styles

Types of Attachment. Researchers have proposed categories of attachment. *Understanding these patterns helps us recognize the attachment problems underlying behavioral and emotional problems.*

The caregiver's own attachment history shapes how he or she shapes the child's attachment style! Parents who shape insecure attachments may be traumatized themselves, attachment-wounded in their own development, dismissive of the child's attachment, contact-avoidant, depressed, preoccupied, physically ill, or drug dependent. *So the parent reinforces, extinguishes, or punishes the child's various ways of approaching.* Here are the subtypes of attachment.

1. **Secure.** Optimally-parented small children cry and miss parent(s) during absences and are quickly comforted upon reunion with caregiver, showing joy, relief, excitement and other positive affects. They seek out parents and feel safe knowing where a parent is. They learn parents may go, but always come back. This leads to effective brain development, identity, and self-regulatory skills.

2. **Insecure-Avoidant** These children show little distress during separations, avoid contact when mother returns (protest behavior). This generalizes to avoidance of close contact with others. They do not make friends easily and do not maintain those friendships they do have, thus isolating themselves Their mothers are often withdrawn, distant, or attachment-rejecting types or who extinguish attachment behavior. As adults, they may both want connections and then pull away from them.

C. **Insecure-Anxious/Ambivalent** Separation distresses these children; they are not easily soothed upon reunion. Their mothers are available, but unpredictably, and may intrude upon, control, or inhibit exploration of the environment. Alternatively, they may not provide a safe base for the child's explorations. These children may do what they want to do, and may do not consider consequences. Sometimes, in order to be elicit caring, they may try to be who they think others want them to be. Then they are extremely anxious about how they should behave and mold themselves easily to whatever expectations they believe others have for them. As adults, they often form intense connections quickly, then become very anxious they are not good enough or the person will reject them or they have not done enough to keep love.

D. **Insecure Disorganized/Ambivalent** These children show conflicting patterns, with protest

upon reunion (withdrawal) or approach the caregiver, but not all the way. They may cling and seem distant at the same time.

Internal Working Models of the World

Let's look at the 6 elements we posit are part of the child's *Internal Working Model of the World* above at they show up in Secure Children, Insecurely Attached Children, and Children with RAD. Internal Working Model is a function of the relationship with primary caregiver.

Internal Function and Learning	Quality in Secure Attachment	Insecure Attachment	Reactive Attachment Disorder
Basic trust in others	Emotional security, feeling needs will be met, sense of belonging, internalized positive *object constancy*.	Anxious: partial trust, but also worry other will pull away, have to check and re-check lovingness of relationship. Avoidant: mistrusting, pulls away, not to risk disappointment.	Basic mistrust in others, expect they will not come to meet needs, have to take care of self (which leads to many behaviors others find troubling).
Sense of living in a dependable and predictable world	Asks/cries for help expecting it will come, security to have fun & enjoyment, expects support-care-comfort from others, seeks them out, communicates emotional needs openly.	Anxious: seeks intense connection, but then fears it s not reliable. Inconsistent parent leads to confusion in child's attachment. May have an overwhelmed parent, so child feels like a burden. Avoidant: avoid dependency and intimacy as others cannot be relied upon.	Internal working model can be chaotic and disorganized due to the lack of consistent caregiving and affection. They may not develop a clear sense of others as being helpful or reliable and can view relationships as transactional (what you do for me) or irrelevant to their needs.

Sense of self-worth and being special and worthwhile, the self as valuable	Feels loved, child can ask for what child wants, expects to have need a and wants met, takes joy in own creations. Feels validated.	Anxious: Love must be earned (it's not a given) and can be taken away, so self is not intrinsically valued. Needs external validation. Role reversal (caretaking the parent, parentification) may lead to taking care of others at expense of own needs. Avoidant: self-sufficiency to survive in an unreliable world, dismiss others' opinions	Extremely low self-esteem and a sense of unworthiness. They may feel unlovable or worthless, often reflecting the neglect, abuse, and invalidation child received.
Capacity to regulate the sense-of-self in interaction with others, feels effective as an interacting person	Quickly recovers from upsets and frustrations, beginning of positive identity.	Anxious: needs others in order to regulate, becomes enmeshed, then anxious about keeping the other's love and valuation. Intolerant of aloneness. Avoidant: pulls back from feeling engulfed and unsafe, so self seems self-sufficient while actually being reactive to others.	Incoherent sense of self. Their identity development can be adversely affected by the lack of stable attachments, leading to confusion about their place in the world. Sense of effectiveness comes from finding sources for meeting basic survival needs.
Capacity for effective autonomy	Can explore the environment knowing child can return to safety with the parents, expects to *do* good.	Anxious: struggles for reassurance of being wanted/loved, dependent in relationships Avoidant: withdraws to maintain self-direction (which is no self-direction as it still requires a reaction to others)	Both needs and disavows others, or may cling and see others as source of meeting needs, may have learned to get survival needs met.
Capacity to regulate emotions, emotional arousal, and calming or soothing after a disturbance in emotions	Learns self-soothing, how to calm, internalizes the comforting that child receives and can do that for self	Anxious: can be intense and overwhelming in relationships, becomes highly anxious with limited self-soothing. Avoidant: suppression and denial of emotions.	May exhibit impulsive, reckless, or inappropriate behavior without consideration of consequences, partly due to their failure to form healthy attachments and learn appropriate behaviors.

Failed Attachment and Reactive Attachment Disorder

Unfortunately, some children are exposed to breaks with attachment objects and distortions of the attachment experience, such as neglect or abuse – the most severe *attachment wounds*. Prolonged separations interrupt the child's relationship with those he or she associates with

love, comfort, and safety. Separations or abuse, sometimes even medical procedures that separate child and parent, leave the child feeling the world is not a safe place after all. After a while, the child may conclude that seeking love and attachment is hopeless and that, even when parents return, security can not be trusted.

Beliefs in Wounded Attachment. In attachment disorder, the child develops even more distorted schemas for comprehending Self-in-the-World. These include notions such as the following primitively guilty and shameful beliefs:

- *I have to meet my own needs as no one else will.*
- *Having or showing a need is dangerous; it will lead to harm.*
- *Caretakers are dangerous. They cause hurt.*
- *I will never be loved (safe, believed, validated, appreciated).*
- *Caretakers go away and leave me helpless, hopeless, empty, bereft, alone.*
- *No one will control my impulses, so I may do terrible things.*
- *The world is a dangerous place in which people are not in control.*
- *The reason I am not loved is I am basically bad.*
- *Trust no one.*
- *Caregivers (or other intimates) are the enemy; get close and you'll be hurt.*
- *Test people to make sure they won't leave like everyone else.*
- *The slightest reprimand, disinterest, punishment, scolding, or cross word shows that person does not want you and will get rid of you.*
- *I can get any likely person to take care of me and maybe this time someone will meet my needs.*
- *Don't get close and you won't get hurt.*
- *Leave the other before he/she can leave, hurt, disappoint, or reject you.*
- *Don't even show you have needs or vulnerability.*
- *People are betrayers. When you need them they side against you or leave you alone. Take care of yourself.*

***These beliefs often appear not so much in actual words and language as in the beh*avior. They are encoded in our ways of acting and reacting.**

The child may not develop ***object constancy***. Object constancy is the internal representation of consistent parents and parenting, which ordinarily maintains internal feelings of self-soothing built on memories of positive care. It means inside the child is the rich memory of good parenting and co-regulation; the child unconsciously draws upon that to soothe his or her own feelings, to expect things to turn out all right, to expect to be taken care of. *This is all internalized unconsciously into our personalities. It's encoded within us, in the brain, in the*

personality.

Effect on Development. Because of the failure of positive object constancy and co-regulation, the dysfunctional *attachment cycle* results in a heightened level of limbic (affective) reactivity, impaired cortical control over planning and inhibition of behavior, reduced brain structure for soothing, increased brain connections for arousal of negative emotions associated with daily events, and an impaired ability to internalize a working Internal Working Model of a safe world.

Nor is the child's self-representation fully integrated – his or her perception of Self could come to be a mix of good experiences of doing things which aroused a parent's love, and bad ones of feeling he or she did things which aroused abandonment and rejection, implying the child is not entirely lovable. The child may lack cause-effect thinking, understanding of consequences.

You can see how deeply the brain's development is shaped by early parenting!

Reactive Attachment Disorder (RAD RAD is a persisting, unremitting, pervasive mental condition beginning in the first two years of life, impairing *the ability* to bond, attach, or trust caretakers. Trusting means *to love and rely upon* – but **this child learned that trusting, wanting, waiting, needing, and loving *hurt***. The child learns that trying to get others to meet these needs will be extinguished (ignored, rejected, abandoned), or will be punished. Consequently, he/she allows loving only on his/her terms so as not to be hurt again. The child will attempt to control the world so no one gets into it, past the child's barriers, without proving trustworthiness. Unattached children often appear attractive, bright, helpless, lost, or creative, as may suit their needs at the time. Many of these children also have PTSD as a result of significant abuse histories.

Causes of RAD Any of the following, occurring to a child under 36 months of age, puts a child at *higher risk* for an attachment disorder. Remember risk factors are not always causes.

- ✓ Maternal ambivalence toward pregnancy
- ✓ Unprepared mothers with limited emotional attachment to the pregnancy.
- ✓ Poor parenting skills, such as overly frustrated with the baby or inconsistent responses to child or being overwhelmed by baby
- ✓ In-utero trauma, drug or alcohol exposure
- ✓ Premature birth leading to impairment in bonding
- ✓ Physical, verbal, sexual or emotional abuse which produces prolonged alarm/stress reactivity
- ✓ Caregiver neglect of the child's physical or emotional needs

- ✓ Several moves and/or foster placements early on, orphanage upbringing
- ✓ Inconsistent/inadequate care
- ✓ Prolonged separation from caregiver (i.e. illness, hospitalization, or death of mother; chronic child illness or hospitalization)
- ✓ Undiagnosed or painful illnesses
- ✓ Inappropriate parental expectations regarding child development
- ✓ Chronic maternal depression
- ✓ Other early traumatic events

Treating Attachment Disorder

1. Biologic – medication does not treat RAD or attachment wounds, but can impact some of the symptoms, e.g., medication to mediate hyperarousal, medicate anxiety or depression, medicate AD/HD, control aggressivity. E.g., Clonidine or Tenex for brainstem arousal E.g., Risperdol for aggression. SSRI for mood problems & PTSD. Psychostimulants for AD/HD.

2. Environmental - *to educate caregivers and for advocacy*. Topics: symptoms of RAD, PTSD, emotional neglect; management of behavior *without parental arousal-reactivity*. School consultation, team approach. Avoid splitting and triangulation amongst the team – needs a cohesive team. IEP evaluation for LD, AD/HD. Caregiver needs to desire to make a difference for the child, not to be punitive or rejecting (which the child will provoke), must learn to be attuned, not take child's behavior personally, to regulate own emotions, to meet personal needs in other arenas than with the child, to accept conflict, to use mainly positive reinforcements. If the child makes poor choices, get closer anyway. Create a life photo journal.

Encourage eye contact for interaction. Use loving touch, with child's permission for touch. Be empathic about the child's inner struggle. Work in conjunction with the professionals involved. Hold child accountable by asking the child to suggest consequences, but *do not use punishments as punishments as they are interpreted as personal rejections*. **Never use guilt or shaming or rejection as punishments with children who have wounded attachment.** These all confirm the child's Internal Working Model of the World and do not change it. Create rituals for 'arrival day' for foster/adoptive kids. Unfortunately, parents often have attachment, AODA, & trauma problems of their own.

3. Psychological - *to resolve trauma and improve attachment capacities*. *Attachment-Based Therapy* includes therapeutic processes designed specifically to promote, develop or enhance a reciprocal attachment relationship. [Note: This is not "Attachment Therapy," which is one approach that has a tarnished reputation.] The goals of treatment include

- validating the child's feelings
- helping the child identify, appropriately express, and regulate feelings
- help identify and articulate the child's Internal Working Model of the World
- resolve early trauma
- work through grief and loss
- cognitively restructure faulty thinking patterns about relating
- learn to see the world and his or her place in it in more realistic terms
- help the child develop positive sense of identity
- help child down-regulate and co=regulate emotional states
- help the child learn how to relate to others in a respectful, responsible, and reciprocal way
- help the child develop thoughtful decision-making skills
- help the child to experience and to accept loving, nurturing care
- increasing the child's self-control abilities
- help see the connection between present attitudes and past experiences.

What Parents Do Matters Completely. This is mainly a family therapy approach using high levels of parental emotional attunement. If we all remember the child's brain developed to manage in one world in which attachments are wounded and we are trying to have the child learn to respond differently, then the world cannot be like the damaging one; it needs to supply the attunement, patience, and care that was missed – with unwavering patience.

Parents learn effective parenting techniques.

RAD-Reactive Attachment Disorder

Some of the symptoms and behaviors associated with RAD [not all will be seen in any one child] – children unable to form lasting attachments

- abandonment fears easily activated
- body function disturbances in sleeping, eating, urination, defecation
- compulsively controls/world others to protect emotional supples, food, basic needs
- control problems, sometimes overtly, sometimes through covert or "sneaky" behavior
- destructive to self, others, animals, material things; accident prone; stealing
- dissociation is sometimes seen, with withdrawal
- hoarding, stealing, gorging, garbage-picking
- impaired play behavior
- inappropriately demanding and clingy
- indiscriminately affectionate or friendly with total strangers, or seeking close physical proximity inappropriately
- talkative with strangers, goes up to strangers without fear, expecting something from them
- lack of impulse control and cause-effect thinking (connection of one's actions with consequences and outcomes)
- lack of eye contract when others expect it
- lack of empathy for others
- lack of conscience, lying about the obvious
- lacking ability to give or receive affection (not cuddly, empathic, or warm)
- manipulative, superficially engaging, charming (has learned that a cute, provocative, or pleasant demeanor leads to safety or getting food, help)
- marked control problems, defiance, and anger
- need for others may be disavowed or dissociated
- not aware of others' selves as different, relates to them as gratifiers of his/her needs
- not affectionate on parents' terms
- pervasive feelings of shame, feelings of badness or worthlessness or aloneness
- relationships come and go, lacking solid connection to them
- poor peer relational behavior
- preoccupation with fire, blood, gore
- uncomfortable when faced with real attachment

Remember, any of these behaviors that may look "anti-social" are actually the child's idea of their way to survive!

- Identify and alter negative interaction patterns.
- Resolve their own attachment wounds.
- Resolve own problems with grief and loss.
- Provide *Holding environment,* i.e., the best balance between support and structure.
- When anger or emotion is activated, the fact the child is not rejected for those feelings can be used to modify the world view.
- Trace out patterns of anger.
- Provide uncompromising support.
- Address hidden doubts of emotional and personal safety.
- Provide steady control and limits without rejecting child.
- Accept ***bids*** for appropriate closeness, thus reinforcing child's positive approach to others.
- Determine incomplete developmental stages and accept behavior appropriate to that point in development.
- Identify and label emotions.
- Use *reflection* of emotions and *active listening* techniques.
- Address the trauma and loss directly.
- Appropriately direct anger and blame.
- Don't take the child's behavior personally.

If your structure is too severe, then the child will not bond to you. Don't take the child's behavior personally. Don't give up hope of finding help/resources.

Most traditional therapy involves talk

therapy, and is based upon the development of a *therapeutic relationship* between therapist and client. This relationship requires mutual trust, respect, reciprocity, emotional honesty, and the ability to formulate thoughts and feelings into words. Children with Attachment Disorder are unable to make use of such methods because:

- They do not trust.
- They are not emotionally honest, and in fact are frequently not able to identify their feelings or what is behind those feelings.
- They do not very well respect anyone, including themselves.
- They are not capable of reciprocal give and take relationships.
- Their backgrounds of abuse, neglect, unresolved trauma or pain, loss and abandonment frequently occurred during the first year or two of life, prior to conscious memory of events.
- They may not know why they feel and act as they do.
- They are operating in the only way they know how to survive.

The key to treatment is EMPATHIC ATTUNDEMENT with the child's mental state of anxiety, understand the child's behavior in light of the fear and anger brought about by failed attachment, the wariness of connection, the internal logic of the child's symptoms, and the child's world view. The child's view represents his or her experience with attachments as painful and frustrating and unreliable. The child's schema of relationships is primitive and damaged, and it does not admit of new, successful relationships. *Attunement with this reality of the inner world of the child is more important than behavioral management and control.*

With the right parenting approach and the right therapy, these children can become much more functional, that is, work toward goals, related effectively, develop of more functional narrative and world view, and have positive belief systems. *It takes patience and acceptance.*

Do you want to understand RAD from the child's point of view. Read our paper *From the Mind of a Child With Reacitve Attachment Disorder.*

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