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Recommendations for terminating with child clients diagnosed with reactive attachment disorder

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Recommendations for Terminating with Child Clients Diagnosed with
Reactive Attachment Disorder
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A research project submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

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Abstract

Clients diagnosed with reactive attachment disorder have mental health struggles which originate from the quality of significant relationships. Therefore the ending of the therapeutic relationship with these clients presents notable risk and opportunity. This thesis contains an extensive literature review that covers reactive attachment disorder treatment recommendations and termination recommendations. A journal article manuscript follows which provides suggestions and considerations for terminating counseling with child clients diagnosed with reactive attachment disorder.

LITERATURE REVIEW

One client stands out from my work doing intensive therapy with children. She was a child with a diagnosis of reactive attachment disorder (RAD), and as a novice counselor that diagnosis intimidated me more than most things I encountered in my work. Both the challenge of working with Khin (the client's name has been changed to protect confidentiality) and the relationship we developed gave her special importance in my mind. More influential than that, however, was Khin's diagnosis, and my fears around how to best address it. Since I was a beginning counselor, I had a sense of how deeply RAD affects children, and did not feel informed and experienced enough to be helpful to Khin. In fact, I was afraid providing treatment that I knew to be effective with other children might damage her because of her unique needs. In particular, termination was a large concern for me. Khin's RAD resulted mainly from a sudden separation from her primary caregiver. As we developed a stronger and stronger connection, I began to dread the time that I would have to end counseling with my client—even when that point was months away.

Termination with young clients diagnosed with reactive attachment disorder is a crucial topic. Because children diagnosed with RAD have attachment difficulties, special consideration needs to be given to terminating with them. Whether a counselor has formed a close bond with the client, or worked primarily through the caregiver, termination of counseling is a critical time that carries many risks and much potential for a therapeutic emotional experience.

This literature review will begin with an examination of the definition and hypothesized causes of reactive attachment disorder. I will then investigate the current

RAD treatment recommendations. Finally, I will review effective practices for termination in general and termination with child clients. Using the information from this literature review, I composed a manuscript to submit for publication to practicing counselors (See Appendix A). The article manuscript describes treatment considerations for terminating with children diagnosed with RAD, and offers my work with Khin and others as case study examples.

Attachment

Overview of Attachment

Attachment is the organization of behaviors in a child that serve to create closeness with a caregiver in times when the child wants comfort and nurturance (American Academy of Child and Adolescent Psychiatry [AACAP], 2005). As a child develops, attachment permits a child to explore and feel safe through maintaining proximity to the caregiver. Children form secure attachments when they can expect and rely on the responsiveness of their caregivers. The formation of that secure attachment with an adult caretaker is an essential part of healthy development. Attachment is key to an individual's mental health because it plays a role in an individual's sense of self and influences an individual's ability to effectively manage emotions and behaviors (AACAP, 2005; Hornor, 2008).

John Bowlby is credited as being the first to articulate attachment theory, which is a theoretical approach to relationships between parents and children (Blount-Matthews & Hertenstein, 2005). Attachment theory holds that because human infants are dependent on caregivers for their physical needs, they are evolutionarily primed to develop an

enduring bond with an adult early in life. The theory suggests that caregiver characteristics support a child's healthy attachment development. These characteristics include stability in environment, sensitivity to the child, and responsiveness to the child's needs (American Professional Society on the Abuse of Children [APSAC], 2006; Hardy, 2007).

Since this early acknowledgement of the importance of attachment, scientific studies have identified a number of biological processes that rely on a healthy attachment. Brain development, including the creation of neural connections, takes part primarily in the first three years of life. Ninety percent of an individual's neural connections are made during this time. Biology determines an individual's capacity for cell development, but experiences, such as interactions with a caregiver, influence how many neural connections actually form. An individual's ability to regulate affect over the lifespan is also influenced by biological processes in early childhood development. A child's experiences are crucial to right brain development, and the right brain processes social-emotional information and manages affect. Therefore, interactions between a child and caregiver are key to the child's ability to regulate emotion both as a child and later as an adult (Hough, 2008).

When a child's physical and emotional needs are not met early in life, there are biological consequences that contribute to a child's maladaptive behavior. In a 1950 report to the World Health Organization, Bowlby described his work with homeless children in London after World War II. He claimed that the disruption in caregiver relationships in the first three years of life put children at risk for behavior problems (Haugaard & Hazan, 2004). Bowlby's research formed the basis for the identification of

reactive attachment disorder. RAD sometimes occurs in children when they have experienced weak or disrupted attachments with caregivers. Individuals with RAD diagnoses can have significant behavior problems in childhood that disrupt their social and academic growth, and the effects can last into adulthood.

Definition of Reactive Attachment Disorder

Reactive Attachment Disorder was first defined in the American Psychological Association's third edition of the Diagnostic and Statistical Manual (DSM) in 1980. The current Diagnostic and Statistical Manual, the DSM-IV-TR, defines Reactive Attachment Disorder as "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years" (APA, 2000, p. 127). This disturbed social relatedness has to be evident in one of two ways. The first is that the child does not respond appropriately to social interactions, instead responding with a combination of avoidance, opposition to soothing and approach, or the child may become extremely still, quiet and observant. The second way that disturbed social relatedness can be evident is indiscriminate sociability, commonly taking the form of acting overly familiar with strangers (APA, 2000).

The DSM-IV goes on to distinguish that the inappropriate social relatedness cannot be caused by a developmental delay, and that there must be pathogenic care. Three examples qualify as pathogenic care. They are consistent neglect of the child's basic needs, either physical or emotional, or repeated caregiver changes that prevent the child from forming a secure attachment. The final part of the definition notes that it is

assumed that the pathogenic care causes the inappropriate social relatedness that distinguishes children with RAD diagnoses (APA, 2000).

It should be noted that one significant weakness in the RAD diagnosis comes from van der Kolk, et al. (2009) in a proposal to include a new diagnosis in the fifth edition of the Diagnostic and Statistical Manual. The authors proposed a diagnosis of developmental trauma disorder (DTD) to better represent the experiences and symptoms of children who face continuous interpersonal trauma. They argued that such children are being misdiagnosed with conditions including conduct disorder, posttraumatic stress disorder, separation anxiety and reactive attachment disorder. The authors specifically indicate that while RAD and DTD overlap in many ways, the RAD diagnosis does not address an enduring negative sense of self or the consequences of interpersonal violence. Additionally, the RAD diagnosis does not address the behaviors of affect dysregulation, aggression, self-harm, self-soothing, and risk-taking. After a great deal of discussion, DTD is not slated to be included to the new version of the DSM. The RAD diagnosis will change significantly in the DSM-V in that it will be split in to two disorders: reactive attachment disorder of infancy and early childhood and disinhibited social engagement disorder (APA, 2010). These modifications of RAD will alter the framework for the diagnosis, however, the importance of successful termination for children meeting the criterion for either of the proposed disorders will continue.

Subtypes

Within the diagnosis of RAD, there are two types of the disorder: the inhibited type and the disinhibited type. A child is classified as having the inhibited type of RAD

if the child has the mixture of avoidance, resistance, and approach or if the child has the extreme state of being quiet, observant, and still, known as *frozen watchfulness*. If, however, a child diagnosed with RAD shows an indiscriminate sociability, being overly comfortable with strangers and not showing a strong attachment to one particular adult, then that child is classified as having the disinhibited type of RAD (APA, 2000). The two types look very different in terms of a child's daily behavior. The inhibited type is easiest to recognize when a child's behavior toward important adults is hard to predict. The disinhibited type is recognizable when a child consistently treats adults, including strangers, in ways that children typically treat close family members. These children appear to lack normal interpersonal boundaries.

The pathogenic care responsible for RAD takes two different forms, and those two distinct kinds of care lead to either the inhibited and disinhibited types of RAD. The inhibited type results when a child needs comfort and experiences hostility or rejection from caregivers. The child then comes to expect this behavior and instead of communicating emotional and physical needs, the child often avoids social contact. Behaviors that seem aloof or inconsistent often stem from a fear of hostility or rejection as the child has previously received. The caretaking behavior that leads to the disinhibited type of RAD is distinctly different. A child diagnosed with disinhibited RAD has usually experienced inconsistent care: care that sometimes meets his or her needs, and sometimes does not. The child then comes to believe it is possible to get the needed care, but feels he or she is responsible for making sure the caregiver recognizes the needs. Therefore the child acts in attention-seeking ways and often exaggerates need

in order to persuade adults to provide for physical and emotional needs (Haugaard & Hazan, 2004).

Long-term Effects of RAD

The effects of RAD can be life-long and far-reaching. The pathogenic care associated with a diagnosis of RAD can lead to sleep and eating disruption, and can negatively affect immune systems. These physical effects during childhood can lead to negative effects in adulthood (Haugaard & Hazan, 2004). The pathogenic care often includes understimulation and also poor school attendance which can cause academic difficulties. The subsequent poor academic achievement can have life-long consequences. Finally, the behavior characteristic of RAD, namely inconsistent responses to care, frozen watchfulness, or being socially indiscriminate, can all lead to impaired peer relationships in school and as an adult (Crosson-Tower, 2002 as cited in Webster, 2005). Notably, Butzer and Campbell (2008) found that adults with anxious attachment styles from childhood have lower levels of sexual and marital satisfaction than adults with healthy childhood attachment styles.

In addition to the physical, educational, and social effects that Reactive Attachment Disorder can have in adulthood, adults who had poor attachments as children are more likely to form poor attachments with their children. Therefore attachment problems often continue from one generation to the next (Cornell & Hamrin, 2008). Weinfield, Sroufe, and Egeland (2000) studied attachment styles in a longitudinal study of children from before birth to the children's nineteenth birthdays. The children were born to mothers with little social support and significant stress and instability. Among

the authors findings were that challenging and chaotic life experiences, which were common within the high-risk sample, tend to equate with less stable attachment representations over time. These life experiences include legal trouble, conflict with family and neighbors, and health, housing, and work problems. Additionally, when the authors observed stable attachment styles within the high-risk sample, the stability was in insecure attachment from infancy to adulthood, and maltreatment seemed to be a factor in that consistency.

RAD Treatments

The literature on Reactive Attachment Disorder does not include extensive evaluations of therapeutic approaches to RAD. In 2006, Stafford and Zeanah (p. 245) noted that no studies at that point “evaluated specific psychotherapeutic approaches” to children diagnosed with RAD. In 2008, Drisko and Zilberstein reported that there was no mention of reactive attachment disorder in either the Campbell Collaboration or the Cochrane Collaboration. The collaborations create systematic reviews of social interventions and human health care, respectively. In a search I completed in 2010, the Campbell review mentioned RAD once, but neither of the collaborations had a review of RAD.

Though there is no significant amount of empirically based RAD treatment, there are publications outlining treatment approaches. This section will summarize several of these therapeutic approaches. Though they take different courses, all of the therapies summarized focus on developing a strong attachment between the child and caregiver, and most focus on addressing the child’s disruptive behaviors. Most of the works assume

that the child in therapy is living with new parents, but the information provided can be useful in cases where the child is continuing to live with the biological parents. In the following summaries, the terms *parent* and *caregiver* will be used interchangeably.

Family Systems Treatment

In a sourcebook on working with attachment disorder children, Levy and Orlans (1998) describe a family systems approach to therapy. The major premise of this therapy is that each relationship within the family is reciprocal. Each family member's behavior triggers a response in each other family member. These patterns within the family keep their particular system going. For therapeutic interventions, Levy and Orlans (1998) stress the importance of empathizing with and supporting the parents. They also highlight the need to confront the parents' attachment issues.

Levy and Orlans (1998) describe the therapist's main role as creating a climate of limits, boundaries, structure, and clear expectations, and modeling that climate for the parents. At the same time, the therapist needs to educate the parents about reactive attachment disorder. Once the child has stopped old behavior patterns, the therapist's work then turns to helping the child and caregivers practice secure attachment interactions, such as the parents holding the child in their arms (Levy & Orlans, 1998). Finally, the sourcebook points to the need for strong communication between therapists, parents, and involved organizations such as social service agencies. Effective communication between the different parties can prevent the child triangulating one system against the other and distracting from the therapeutic work (Levy & Orlans, 1998). It should be noted, however, that in criticizing the weaknesses of attachment

therapy, Prior and Glaser (2006, p.263) note that the Levy and Orlans book, which they state is based in attachment therapy, is “replete with authoritative explanation and advice but contains no account of objectively evaluated outcomes of attachment therapy.”

Stafford and Zeanah (2006) recommend the approach of interaction guidance, which the authors state best fits families with lots of needs, such as a lack of social support and little education. Interaction guidance’s focus is helping the parent enjoy the relationship with the child and gaining a better understanding of the child’s behaviors through play. After sessions, the therapist shows parts of a session videotape and praises the parent for appropriate interactions.

Attachment Therapy

In their 2009 study, Wimmer, Vonk, and Bordnick sought to address the type of claim made by Prior and Glaser. Their preliminary investigation was to evaluate the effectiveness of attachment therapy on reactive attachment disorder in adopted children. To test attachment therapy’s effectiveness, the study compared pretest and posttest results for a sample of twenty four adopted children receiving attachment therapy. They noted that the popularity of attachment therapy was largely a result of anecdotal success. With their study they wanted to empirically answer if attachment therapy decreases the severity of RAD in adopted children and if it improves the children’s functioning in their families. The attachment therapy techniques studied include holding, “the positioning of the child across the lap of the therapist or parent to engage eye contact while discussing issues of past abuse or neglect” (p. 355). This holding is distinguished from the frowned upon holding therapy in that it is not intended to induce rage, and that it is done with the

child's consent (p. 354). In addition to holding, the other attachment therapy techniques used were "narrative therapy, parenting skills training, EMDR, psychodrama, and/or neurofeedback" (p. 355). The study methods included using the Randolph Attachment Disorder Questionnaire and the Child and Adolescent Functional Assessment Scale as two pre- and post-tests (Hodges, 2000; Randolph, 2000). The authors reported significant improvement and claim that the results provide "tentative support" for the usefulness of attachment therapy (Wimmer, Vonk, & Bordnick, 2009, p. 359).

Wimmer, Vonk, and Reeves (2010) followed up the above study with an analysis of how effective adoptive mothers perceive attachment therapy. However, the authors noted in the abstract that the study is not intended to provide definitive answers of effectiveness, and instead to highlight the need for further research. The study followed up with adoptive mothers three years after their involvement in attachment therapy ended (upon termination of the grant funding that provided the therapy). The study asked the following three questions: what were the attachment therapy experiences of the mothers, what were the mothers' views on their current relationships with their children, and finally, according to the mothers, what role did the attachment therapy play in the children's current level of functioning? Through interviews, the authors found that the attachment therapy was "consistently supportive," "emotionally painful," and "physically safe." Mothers described the current relationships with their children as "continuously stressful" but that "the adoptions were unquestionably permanent." Finally, the mothers viewed the attachment therapy as preserving the family structure. The authors noted that these results are not as strong as if the study had compared attachment therapy to other therapeutic approaches for RAD, and that the children did not show great improvement in

some cases. They recommended viewing the study results as a prompt for more discussion.

Dyadic Therapy

In their chapter on attachment disorders, Stafford and Zeanah (2006) described a dyadic approach as the therapist staying flexible to the parent and child's needs while supporting their relationship. The therapist facilitates a corrective emotional experience and prompts changes in the parent-child relationship.

Mroz and Rubin (2005) described a dyadic approach that focuses on three relationships: the one between child and therapist, the one between child and caregiver, and the relationship between therapist and caregiver. They speculated that when therapy happens only between the therapist and the child, it reinforces the separation from others that a child with reactive attachment disorder already feels. The parent needs to be present in order to be a part of the love and acceptance the child experiences (Mroz & Rubin, 2005).

In the dyadic therapy that Mroz and Rubin (2005) described, the therapist needs to incorporate four qualities represented by the acronym PACE: playfulness, acceptance, curiosity and empathy. The authors also emphasized that the parent needs to integrate all of those qualities, with the added condition of love, symbolized by the letter *l* in the new word PLACE. With the original PACE qualities, the therapist creates opportunities for the child and parent to feel close, and encourages discussion of topics such as trauma and pain.

Within this approach, Mroz and Rubin outlined eight steps to therapy sessions involving therapist, child and parent. The first step involves the therapist identifying a recent behavior to explore in the session. The second step is revealing the child's belief that underlies the behavior, and the third is empathizing with that belief. In the fourth step, the therapist normalizes the behavior within the framework of the child's belief. Next, in the fifth step, the therapist explores implications of the belief, such as verbalizing what it would mean if the child's belief was true. This stage can often invoke an emotional reaction from the child. Therefore, the sixth step is to empathize with the belief's implications. In the seventh step, the therapist provides the parent with an opportunity to empathize with the child. Even though the parent was there to witness the discussion, this can involve describing to the parent what just happened. When the parent empathizes without trying to quickly fix the distress, the child and parent can eventually talk about the child's emotions, beliefs, and behaviors, and the parent can correct the child's distorted interpretations. In the eighth and final step, the therapist revisits the behavior and includes the child's reasoning for it. Then the therapist can suggest new ways of behaving when the child has similar feelings in the future (Mroz & Rubin, 2005).

Circle of Security™

Stafford and Zeanah (2006) recommended an approach called Circle of Security™ (COS), which has the goal is of increasing the parent's sensitivity to the child. The framework of COS hinges on the caregiver being a secure base for the child. Under the model, the child can explore and return to the caregiver when feeling scared or threatened. Children with secure attachments can indicate that they need to feel

attachment or that they want to explore in direct, easy-to-understand ways. However, children with insecure attachments often send miscues. Miscues are behaviors that appear to communicate that a child does not want what he or she actually wants. Therefore, a significant component of COS is providing information to parents in the context of a caring and respectful relationship to help them be accurately and sensitively attuned to their children.

One outline of Circle of Security™ demonstrates how the approach can be used with children from toddlerhood to the early school years. In a study of at-risk children and their primary caregivers, therapists provided group therapy that started with psychoeducation and then shifted to focus on each caregiver for three sessions each. Therapists created individualized treatment plans for each caregiver that identified interaction patterns, the developmental history of caregiver and child, and the central issue that was the focus of the counseling work. Therapists used video segments of the caregiver and child to spur discussion of the relationship. The pre-test/post-test study indicated that participation in the COS program can reduce insecure and disorganized attachment for young clients (Hoffman, Marvin, Cooper & Powell, 2006). It should be noted that while the Circle of Security™ has its origins as a group therapy approach, the developers are now adapting it for individual counseling and in-home counseling settings.

Behavior Management Training

Another case study involves a seven year old girl who recently came into the care of her grandparents. Her problematic behaviors included being defiant, giving painful

hugs, eating with neither silverware nor her hands, self-touching, and inadequate cleaning after using the bathroom. The authors described a behavior management training (BMT) approach to treating the young girl with her grandmother. Buckner, Lopez, Dunkel, and Joiner (2008) outlined a ten session treatment program to address the child's behaviors. The BMT approach incorporates psychoeducation, parenting skills, and reward systems to improve the child's behavior.

The behavior-centered approach reportedly had a great success with the two major goals of therapy: reducing negative behaviors such as painful hugging and self-touching, and increasing positive behaviors such as complying with caregivers at school and at home. The authors asserted that attachment therapy has not been proven effective, and that their case study highlights an argument for research to be done on the effectiveness of BMT (Buckner, et al., 2008).

Observations and Considerations Regarding Treatment

Several observations about adoptive parents might also highlight components of successful reactive attachment disorder work. For their 2008 exploratory study, Drisko and Zilberstein collected data on nine children in Massachusetts whose clinicians reported RAD symptoms and conditions and who made improvement during treatment. They reported several characteristics in the adoptive parents that appear to help the adoption success. Parental traits included demonstrating commitment to the child, an ability to find strengths in the child, and attunement to the child's emotions. Attunement can be especially difficult because children diagnosed with RAD commonly give miscues, behaving in ways that imply an emotion which conflicts with their actual inner

experience. Additionally, parents sought social supports and educated themselves about RAD.

Drisko and Zilberstein also noted components of treatment that parents named as helpful. These include clinicians emphasizing the important role the parents play and clinicians offering a language with which children and parents can name and discuss issues. Parents also found behavior management techniques helpful and appreciated clinicians' abilities to highlight progress which helped the parents during discouraging times.

Brisch (2002) did not outline a practical guide to therapy, but instead offered many considerations for practitioners facilitating psychotherapy with children diagnosed with RAD. The first consideration is to be a reliable emotional base for the child. This enables the child to experience a secure attachment despite the disorder. The therapist encourages communication around past and current relationships in three ways. The first method is to facilitate play in which the child can express past experiences of relationships. The second is to narrate and interpret interactions between the client and the therapist. The third method for encouraging communication of relationships and attachment is to promote emotional expression around transference experiences as they relate to the child's attachment history.

In a chapter on attachment disorder, Stafford and Zeanah (2006) stressed three things that must be attended to before beginning an intervention with a child diagnosed with RAD, then outlined three recommended intervention types. First they urged practitioners to assess the child's safety. They also acknowledged that many families with children diagnosed with RAD are impoverished and will need community systems

support for their physical needs. If the child is staying with the family and the family's physical needs are being met, the next critical step is to address the parents' barriers to effective parenting and to forming attachments. These barriers are most commonly depression, substance abuse, unresolved trauma, and domestic violence. Stafford and Zeanah (2006) then went on to outline three recommended intervention approaches: child-parent dyadic psychotherapy, interaction guidance, and the Circle of Security™ approach.

Integrative Approaches

Cain offered another behavior management therapeutic approach. In her 2006 book, Cain suggested many strategies in working with a child client diagnosed with RAD that she emphasized should be applied in unique combinations given the needs of each particular situation. The strategies she outlined incorporate ideas from a number of theories including family systems and cognitive behavioral. The goal of working with a child diagnosed with RAD according to Cain is to understand the purposes of problem behaviors and to help the child learn new behaviors. The main strategies that Cain outlines are structure and routine, consistency, touch, neutrality, respect for authority and self-calming techniques. Specifically, touch should be on the caregiver's terms. Even if the child is resistant to touch, the caregiver can start slow, incorporating some "snuggle time" into each day, gradually increasing the length of time. Neutrality covers the caretaker's need to not get triggered by the child's difficult behaviors. Lastly, self-calming techniques are important for children diagnosed with RAD because such

children are often in a heightened state of anxiousness and alertness and need to learn ways to shift that heightened condition to a calmer state.

Another integrative approach is outlined in a case study which uses an integrative play therapy approach (Weir, 2007). The integrative approach is a model for clinicians designing interventions for clients diagnosed with reactive attachment disorder. Weir's approach combines structural family therapy, play therapy, and Theraplay®. The case study involves an eight year old male client who was abused by his biological mother. After being with his adoptive family for five years, the adoptive mother was at a breaking point. She stated that if therapy didn't work, she would have the son live with a relative or would "give him back to the agency" (p. 4).

Weir described working to strengthen attachment through modified Theraplay® activities that encourage "structure, engagement, nurture and challenge" (p. 5). He described these activities in some detail in order to illustrate them for clinicians to consider using. Weir also assigned homework to encourage healthy attachment. Two examples of activities with positive outcomes include a Mother-May-I/Father-May-I game and an activity Weir calls Happy Ball. The parents reported that playing Mother-May-I/Father-May-I during therapy helped them realize how specific they needed to be with their son at home. The Happy Ball game involved passing a ball and the thrower saying something he or she appreciates about the catcher. This game evolved with the family to be called Emotion Ball and the child client used it to verbalize emotions with his adoptive parents.

Weir reported substantial outcomes. He described the client having a flat affect at the start of therapy and transforming into an engaged boy with a radiant smile by the end.

Weir pointed out that his approach is only developmentally appropriate for younger children because they can enjoy the play described. He also noted that the child's trauma cannot be too recent for this therapeutic approach. While Weir's article reflected a clinician's unique combination of approaches and highlighted only one successful case, his case study seems to serve as a useful example for other clinicians.

School Setting Recommendations

In an article that focused on RAD identification and intervention in schools, Floyd, Hester, Griffin, Golden and Canter (2008) gave broad recommendations for therapy within that setting. They recommended developing child-specific interventions to help children diagnosed with RAD to acquire self-control and self-identity.

Interventions should also be developmentally correct, reduce negative procedures, and emphasize nurturing. In addition to reviewing literature and making recommendations, Floyd et al. noted that it is crucial for school psychologists to inform school staff about the ways they can address the needs of students diagnosed with reactive attachment disorder.

Shaw and Páez (2007) also reviewed effective interventions within the school. Their article focused on interventions for school social workers specifically, but has general implications for all clinicians. The authors recommended service plans that address the child's family, that have quantifiable goals, and that are structured in several phases. Other key points in the article included that clinicians should beware of believing too quickly that a significant relationship has developed with the child, and to be prepared for that process to take an extended time. A final point made in the article was

to “prepare for the worst” noting that in foster care and adoptions children can behave in alarming and destructive ways (p. 73). It can help treatment be successful if families and clinicians know that is normal, if they evaluate caregivers’ characteristics including their affect regulation and stress-management skills, and if they know effective ways to respond to children with RAD diagnoses.

General Treatment Recommendations

While the above mentioned Cochrane and Campbell Collaborations do not have reviews on reactive attachment disorder treatments, two publications which are the group efforts of many authors outlined general recommended practices for children with attachment problems. The American Professional Society on the Abuse of Children (APSAC) made suggestions for the assessment, treatment, and practices around attachment conditions, and the American Academy of Child and Adolescent Psychiatry (AACAP) offered generally accepted ways to assess and to treat reactive attachment disorder.

The APSAC task force offered several specific recommendations based on a review of over seventy studies (APSAC, 2006). The review found that the most effective treatments for increasing a child’s attachment security were treatments that increased parental sensitivity. The review also found that the most effective treatments were the ones that were “focused, goal-directed, and behavioral” (p. 78). Therefore, the authors found that “shorter term, goal-directed, focused, behavioral interventions targeted at increasing parent sensitivity should be considered as a first-line treatment” (p. 87). These first-line treatments should also be based on attachment therapy’s central principals

which include “caregiver and environmental stability, child safety, patience, sensitivity, consistency, and nurturance” (p. 87).

The AACAP authors reviewed over five hundred and fifty sources and presented commonly accepted methods of RAD assessment and treatment (AACAP, 2005). A few significant recommendations will be covered here. The authors cautioned that the methods presented do not create a comprehensive treatment plan, but instead should be considered by clinicians within the context of the specific conditions of the client and the client’s family and all factors that influence a case. The authors stressed that assessment should include evaluating the caregiver’s feelings toward the client and not simply the child’s behaviors. Including the caregiver’s attitudes will assist the counselor in determining the best treatment.

The intervention of primary importance for a child diagnosed with RAD is for the counselor to advocate for the child to have an “emotionally available attachment figure” (AACAP, 2005, p. 1215). The authors noted that sensitive caregiving is significantly more common in families than in institutions. Also, once the counselor determines that the child is in a stable placement, the counselor should focus on eliciting positive exchanges between the child and caregiver(s).

Finally, the AACAP parameters outlined the three modalities for helping a child with a RAD diagnosis. Counselors may work with the child alone, work with the caregiver and child together, or work primarily with the caregiver. According to AACAP, the least ideal approach is to work with the child alone. The authors recommended it as an additional approach to working with the caregiver and child if it might help reduce behaviors that interfere with counseling.

Working through the caregiver has two main advantages. First, it delivers the message to the caregiver that he or she is capable of making the necessary changes. Second, it avoids the risk of the child forming a strong attachment relationship with the counselor when the focus of the work is the relationship between the child and caregiver.

The third modality is the approach that AACAP recommended most. Working with both the child and the caregiver, or dyadic work, is the favored strategy. The dyadic approach involves focusing on parenting strengths when they are observed, and has the clear advantage of being able to focus on the relationship that is key to the emotional health of a child diagnosed with reactive attachment disorder (AACAP, 2005).

Holding

One treatment for reactive attachment disorder that has been well-publicized but has largely fallen out of favor is holding therapy, also known as rebirthing. The concept behind holding therapy is that RAD behaviors result from the rage the child feels about experiencing pathogenic care. Holding therapy involves restraining the child and subjecting him or her to unpleasant stimuli such as tickling and yelling, and persisting even as the child is upset, until the child is exhausted. Practitioners of holding therapy believe once the child is exhausted, he or she is finished expressing rage, and that if the caregiver then takes control, the caregiver and child can form a healthy attachment (Haugaard & Hazan, 2004).

There are significant concerns with holding therapy, namely the lack of evidence to support its effectiveness and the physical and emotional risk involved. Buckner, Lopez, Dunkel and Joiner (2008) pointed to the existence of only one study on holding

therapy, and list several limitations of that study's findings. The emotional risk stems from the likelihood that children diagnosed with RAD have experienced some trauma and the likelihood that holding therapy could continue the trauma. The physical risk is documented in instances of physical injury and even death (see Mercer, Sarner & Rosa, 2003, for information on one holding therapy death). The current literature acknowledges the existence of holding therapy, but dismisses it as unsafe. In fact, when Buckner, et al. (2008, p. 291) stated that "numerous mental health professionals...warn against the use" of holding therapies, the authors referenced six studies to support that claim. Also, in a study of components of effective interventions for nine children with RAD diagnoses, Drisko and Zilberstein (2008) pointed out that holding was not a part of any of the interventions. While they were not able to point to proof that holding therapy is ineffective from their study, they did posit that their study demonstrated that holding therapy is clearly unnecessary for successful treatment. Prior and Glaser (2006) asserted that there is no evidence base for holding therapy and it directly contradicts Bowlby's attachment findings. Stafford and Zeanah (2006) also stressed that practitioners should avoid holding therapies. Finally, neither the American Academy of Child and Adolescent Psychiatry nor the American Professional Society on the Abuse of Children endorse holding therapy for treating reactive attachment disorder (APSAC, 2006; AACAP, 2005).

Termination Treatment Literature

Recommended Use of Termination Phase in Treatment

While termination can be seen as simply the end of counseling, it is an important part of the counseling process for both adults and children. With any client, termination

has the potential to be a harmful event or to be a therapeutic intervention in itself. This is likely especially true of children diagnosed with reactive attachment disorder for two main reasons. First, the relationship with the counselor can be a significant attachment relationship for the child. Therefore, losing that significant relationship can re-traumatize the child. Second, the effects can be especially harmful because children diagnosed with RAD often lack skills such as emotional self-regulation that would help them cope with such a change. There is a lack of literature on recommended practices for terminating with children diagnosed with reactive attachment disorder. Therefore, in order for the article manuscript to focus on such recommendations, this part of the literature review will examine literature on general termination guidelines including adults and children, terminating with children in general, and terminating specifically with children who have difficult behavior, troubled attachment histories, or multiple losses.

General termination guidelines

Baum (2005) looked at eight variables and how they correlated to clients' behavioral and emotional responses to terminating counseling. The clients were both children and adults with a range of diagnoses, and were referred from social services departments in various cities in Israel. Baum recognized that one weakness of the study is that it relies on reports from student counselors and not the clients themselves. However, Baum reported that the study's findings are consistent with the literature on transitions, which is one way to conceptualize termination. Applying the results showed that the client's experience with termination will be made easier the more that the client has control over it and if the termination is not abrupt. Also, the more that the client

wanted the termination, the more likely he or she is to see it as a positive experience. Baum emphasized that clients should be included in the decision of when to terminate and the termination process should be gradual.

Children termination guidelines

Play therapy

In a book on play therapy, Kottman (1995) outlined a number of useful considerations around termination, including how to warn the child, how to provide children with advanced warning, how to help children process termination, and to explain to caregivers that regressing to past behavior is normal. Kottman offered that she usually informs child clients about an approaching termination when there are around four sessions left. Recommended components of termination included summarizing the progress the counselor has observed in the client in the play room and the progress that others, such as parents and teachers, have observed in the client. A therapist can also elicit the child's feelings around change in general. Next, the therapist can frame that because of the progress, the child no longer needs the help he or she has been getting in the play therapy. Kottman recommended watching for any negative reactions in the child at this point, and responding appropriately. If the child does not have concerning negative reactions, the therapist can reflect the child's emotions. Finally, Kottman pointed out that a child repeating past problematic behavior when nearing termination is normal. It can be a way to process the therapeutic progress and should not be seen as true backward movement. It is best to warn others- caregivers, teachers, etc.- about that possibility so the child does not revert to old ways of responding.

Landreth (2002) also emphasized a smooth termination, avoiding anything abrupt. His play therapy book included many other points around a successful termination. Therapists should avoid trying to help the client feel better. Feelings of loss and sadness, and even of being punished or abandoned are normal reactions to a relationship ending. Therapists need to reflect and acknowledge such emotions to help children process the relationship end. Landreth also warned against therapists sharing their own emotional reactions such as the fact that the therapist enjoyed the time with the client or that the therapist will miss the client. He posited that such statements can spur guilt in the child and should be avoided. Practical tips also include tapering sessions at the end if appropriate and stating clearly at the start of the final sessions how many more sessions remain. Finally, the book alerts therapists that final sessions can often include surprise. Clients' behaviors can change from otherwise predictable conduct, but such change in itself is usually normal.

Terminating with "Difficult" Youth

In a book about counseling difficult young clients, a chapter entitled "Ethical Endings" outlined many components of a healthy termination (Sommers-Flanagan & Sommers-Flanagan, 2007). Because the focus of the book was children and adolescents who are often resistant and confrontational, it may stray further from relevant recommendations for terminating with children with RAD diagnoses, however, many of their suggestions can be useful for clients diagnosed with RAD. The bulk of the chapter concerned the way in which different termination contexts can affect counselors and how counselors can best approach those different situations (i.e. parent-initiated termination

and sudden termination). The chapter also included a list of suggestions that can apply to most or all terminations, and many of these can be applicable to terminating with a young client diagnosed with RAD.

The authors recommended counselors track progress toward termination throughout counseling instead of addressing the topic only when approaching the end. When termination is approaching, a counselor can share a memory from early in the work with the client, presumably to help the client process the upcoming ending and to process the counseling experience. Counselors can identify progress that a client has made, and can also state an observed positive quality of the client's. The authors acknowledged that there will always be unfinished business, and propose that counselors encourage clients to make progress with their personal growth after termination. The example sentence the authors gave is, "Of course, your life isn't perfect, but I have confidence that you'll keep working on communicating well with your sister and those other things we've been talking about" (p. 213). Counselors may also prompt a client to give feedback on what the client thinks worked well in counseling, and invite clients to come back to counseling in the future if wanted. Counselors might also let clients know what they hope for the clients' futures.

The authors' final proposal might be most applicable to terminating with clients diagnosed with reactive attachment disorder. They advised that if it is needed, to discuss with a client any wishes to continue the relationship. Clients might want to continue counseling forever or might want to move from a relationship of counselor-client to a parent-child relationship or a friendship. It might be necessary to review the uniqueness of the counselor-client relationship, to explore and acknowledge the client's feelings, and

to process the reactions to the limits of the relationship (Sommers-Flanagan & Sommers-Flanagan, 2007). This can be particularly relevant to work with clients with reactive attachment disorder diagnoses because of the clients' attachment histories. If the client's experience with a counselor is more positive than his or her experience with the caregiver, these feelings can arise. Also if the client has a difficult attachment history, and it is especially difficult to end a significant relationship, feelings of wanting to continue knowing the counselor can emerge.

Attachment Informed Termination

Attachment knowledge itself can inform the theory and practice of counseling termination. Zilberstein (2008) discussed the implications of attachment including the specific challenges of terminating with clients who have trauma history, and how termination interventions can be helped by attachment knowledge. The author noted that clients with traumatic loss history have the most difficult time with the termination process and mourning the loss of the counselor. Such clients can react to termination in a number of ways including "loss, regression, acting out and avoidance" (p. 302). Additionally, further symptoms result when the client feels like he or she cannot return to counseling, sometimes including "anger, rage, anxiety, mourning and abandonment" (p. 302). Zilberstein even purported individuals with difficult attachment histories are sometimes unable to work through the loss. While counseling might help clients strengthen their coping skills, the loss of the counseling relationship can be dysregulating because clients' emotional regulation abilities are so disturbed. Therefore the termination process might need to be reconceived for clients with difficult attachment histories.

Zilberstein noted some helpful approaches to termination. First, when working with children with difficult attachment histories, allowing check-in sessions can greatly ease the child's reaction to the termination process. Highlighting that enduring relationship with the counselor can help the child accept the ending of the current counseling. Also helpful is emphasizing the client's feelings of pride and accomplishment that can accompany the end of counseling. Termination can be difficult with such children when the counseling relationship provides emotional needs that are lacking in the child's life. Zilberstein pointed out that "it is precisely because the therapeutic relationship is so important that ending is so difficult" (p.303). The therapeutic relationship mimics the secure base of early parent-child attachment in that it includes attunement and discussion of emotions. When a counselor has served as a primary or secondary attachment figure, the ending of counseling is improved when other secondary attachment figures, such as teachers, are available to the child.

The ending of an attachment relationship can trigger a child's emotional reactions from his or her attachment history. This can lead a child to seek out the attachment figure, which in the case of termination is the counselor, even more. Research shows that symptoms increase in children separated from their parents when caretakers either minimize or overemphasize the children's emotion (Zilberstein, 2008). Applying those findings, the best proposal for helping attachment disturbed children cope with termination is to obtain an accurate reading of emotions and respond appropriately to those specific emotions. In a related concept, Zilberstein posited that instead of a traditional termination approach that focuses on loss and grieving, the child client with a

difficult attachment history would benefit from an approach that focuses equally on grieving and coping.

An ending excerpt of one case example highlighted features of Zilberstein's approach to termination:

At the next session, Raoul was told that he had really reacted to the idea of saying goodbye. The therapist understood why. He had said a lot of really difficult goodbyes in his life and had worked hard to stay connected to those people even when he did not see them a lot. So, even though he did not want to come each week that did not mean he and the therapist could not stay in touch... The last few meetings were not spent processing losses, but focused on what had been accomplished, what would be remembered and how the connection would endure.

(p. 306)

This highlighted how the counselor should not downplay or over emphasize the child's emotions around termination. When the counselor has accurately assessed the child's emotions, the next step is to help the child cope with them. One method for this is a photo album which Raoul and his therapist created together. The photo album is a form for the narrative of the counseling work they had done together, and helps the client focus on accomplishments and the counselor-client relationship.

Termination as a Key Intervention

Macneil, Hasty, Conus and Berk (2010) emphasized that termination is the most important part of therapy for clients who have problematic attachment histories. They pointed out that termination can be an opportunity with such clients. If done well,

termination can give clients the experiential knowledge that endings do not have to be accompanied by profound loss or trauma.

An article about treating children with multiple losses made a similar point (Many, 2009). Termination is described as a therapeutic intervention in itself for such clients. The author wrote about a program that sees clients five years old and younger who have experienced traumas, often both acute and chronic. The Louisiana State University program's approach was founded in attachment theory. Practitioners there see the relationship between child and therapist as an opportunity to provide stability that is often lacking in the child's, and the child's family's, life. It stands to reason then, that the ending of this unique relationship provides a crucial therapeutic possibility. Many recommended helping the child's caregiver form an ending that is predictable and sensitive to the child. If both the child and caregiver experience such a loss that is not traumatic, they will have a new model for how to manage losses in the future.

Many (2009) named several specific tips for termination. The first regards pacing. If the therapist determines a child might benefit from tapering off, the meetings can become less frequent when approaching termination. For instance, if a therapist and client have been meeting weekly, meetings can happen once every two weeks and then once a month until the final session. The final session can involve a celebration, often including food and a small present. Lastly, if necessary for the individual child, a picture of the child and therapist could serve as a transitional object.

Children with Trauma

In a handbook for counseling children who have experienced trauma, Greenwald (2005) made the point that termination is not just a point to celebrate the child having reached therapeutic goals or reaching psychological health. In a chapter titled “Relapse Prevention and Harm Reduction” Greenwald emphasized that a therapist needs to prepare children for the future. The chapter outlined ways to help clients think through challenges they may face in the months and years after concluding therapy. While the recommendations were specific to children who have experienced trauma such as sexual abuse, the recommendation might be effectively applied to children with reactive attachment disorder diagnoses as well. During the termination process, counselors can facilitate a focus on the future and imagine with the child how new skills and abilities will influence future events and life development.

Termination Recommendation Across Approaches

Ways to Determine Termination Timing.

Many (2009) identified several questions counselors can consider for determining when it is time to end with child clients who have experienced multiple losses. These questions included: Have the client’s identified problems been addressed, does the client now have self-regulation skills, are the client’s affect and internal experience now consistent, has the caregiver become increasingly sensitive to the client’s cues, and does the caregiver now respond appropriately to those cues? The answers to those questions can indicate that it is time to terminate. The topic should first be approached with the caregiver, and if the caregiver is ready to terminate counseling, the topic is raised with

the child client. At that point, older children can participate in determining the timing of ending counseling.

Greenwald (2006) listed several criteria for determining when it is appropriate to terminate with children who have experienced trauma. The first criterion was that the original problems have been resolved. The child should also show minimal or no distress when remembering the trauma(s), and have minimal or no difficulty in managing the trauma triggers. The caregiver(s) must have also adjusted appropriately to the child's improvements. Finally, the child and the caregiver(s) must be able to expect future stressors and be ready to address them appropriately. Greenwald emphasized the point that a child is not ready for termination simply when the child is "all better now" (p. 233). Because the child and family need to be prepared to address future trauma-related issues, the author discusses preparation for the future as a crucial part of the end of counseling.

Two play therapy sources gave varying answers for how to know when it is time to end therapy. Landreth (2002) was unable to list questions as specific as those given by the above authors because "the child-centered play therapist has no predetermined, individually tailored, specific goals for children in play therapy" (p. 357-8). Therefore, there are not specific questions to ask in order to know when it is time to end therapy. Instead, Landreth listed over a dozen questions that broadly determine whether a client is ready to terminate, and over a dozen statements that broadly assess the client's level of change during therapy. Examples from the two groups respectively are "have his forms of art expression changed?" and "child is more inner directed" (p. 358-9). In addition to looking for such readiness and change within the play therapy room, Landreth recommended confirming with teachers and parents that they are observing change.

Their descriptions can play a part in the counselor's determination of when a child client is ready for termination.

In contrast to the broadness of Landreth's criteria, Kottman (1995) recommended using quantitative information to determine when it is best to terminate play therapy. Kottman stated that when it is time to terminate, it should be evident that the goals of the child's behavior have shifted from being negative to being positive. The child's behavior should be more constructive and appropriate. Finally, the shift in behavior should be corroborated by others in a quantitative way. Counselors can ask parents, teachers and school personnel to give numerical estimates of problematic conduct. The involved adults can also give a rating on a ten point scale of how they perceive the child's general affect.

Goodbye Letters.

Goodbye letters are one recommended component of termination. Macneil, Hasty, Conus and Berk (2010) referenced the goodbye letter's place in narrative therapy. They described that the letters can summarize the course of therapy, mentioning specific issues and reflecting on progress. When appropriate, goodbye letters can also include reflection on the counselor's experience, including challenging components, enjoyable components, and lessons learned from the client.

Leaving the Door Open.

One recommendation that appeared frequently in literature about terminating with child clients was to allow clients the opportunity to return to counseling if desired. This

was often referred to as *leaving the door open*. The opportunity for either individual single session follow-ups or to begin counseling again at a later date can help child clients accept the fact of termination (Kottman, 1995; Landreth, 2002; Zilberstein, 2008). When clients feel like the door is closed and there is no option for returning, termination often is seen as a loss or as a rejection. This can result in negative emotions in the client such as abandonment and rage (Zilberstein, 2008).

In addition to leaving the door open, Zilberstein (2008) gave further advice for easing the goodbye between client and counselor. Tapering sessions can be especially helpful for child clients. Experiencing a reduction in counselor contact before saying goodbye can help the child client understand and adjust to the change. The author further advised that instead of cutting off contact once counseling has ended, counselors should consider keeping a connection with clients as needed. This connection can take the form of telephone contact or letters or “more internalized memories and representations” such as photographs (2008, p. 305). Returning to the case vignette of an eight-year-old boy referred to above will highlight several of these ideas:

It was clear that although Raoul did not want to come to therapy, he did not want to end either. Ending entailed confronting a number of losses for which he was not ready... Termination needed to be a less permanent process and one more centered on the continuing availability of the therapist... The therapist offered that they schedule a few more meetings, spaced apart by a few weeks so he could see what it was like to come less. If it felt OK, no more meetings would be scheduled, but he was free to call or make an appointment whenever he wanted to be in touch. Raoul accepted this arrangement and his anxiety and regressive

symptoms quickly abated... Raoul and his therapist made a photo album with a narrative that reflected the work. (p. 306)

This excerpt shows a method for creating a representation of memories to honor the connection between the client and counselor. It also highlights how the use of tapering sessions and the ability for a client to return to the counselor can help the client respond positively to termination.

Counselor Experience of Termination

In termination literature the focus was most often on the client. However, counselors should not focus exclusively on clients and lose track of themselves as an integral part of the process. In fact, when counselors are aware of how termination is affecting them it can help them personally and professionally, and can improve the termination for the client as well. It is normal for counselors to feel a range of emotions and it can be useful to keep track of those emotions and to sometimes seek consultation or supervision from colleagues.

There are a mixture of emotions that a counselor can may feel when approaching termination with a client, and often a counselor will experience several emotions at the same time. Counselors may feel difficult emotions such as disappointment, apprehension and failure, and also positive emotions such as hope and pride (Macneil, Hasty, Conus & Berk, 2010). In addition, counselors may feel anxiety, fear, or anger, and it is important that counselors explore those emotions. Some of these reactions might be instructive to the termination process and some might reflect personal growth areas for the counselors. While feelings of sadness are expected when there's been a connection with a client, if

counselors feel anger or resentment toward clients, it may be beneficial or necessary to explore those with a supervisor (Sommers-Flanagan & Sommers-Flanagan, 2007). Macneil, Hasty, Conus & Berk (2010) also recommended leaving an appointment time open after the closing session with a client as a way for counselors to give space to reactions around termination.

Summary

When I was a novice counselor trying to navigate my way through ending the counseling experience with a young client, I knew enough about reactive attachment disorder to be nervous about how we ended the therapeutic relationship. As a result of consultation and supervision, the termination process with Khin included clear structure and ritual. From the review of RAD treatment literature, and literature on terminating with similar specific child client populations, I now have a sense of other aspects I could have included to make the termination process more therapeutic for Khin. The above examination of applicable literature informs the following article manuscript. It is my hope that the manuscript can serve as a useful contribution for counselors navigating the termination process with child clients diagnosed with reactive attachment disorder.

REFERENCES

- American Academy of Child and Adolescent Psychiatry. (2005). Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 1206-1219.
- American Professional Society on the Abuse of Children. (2006). Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment*, 11, 76-89.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., rev). Washington, DC: Author.
- American Psychiatric Association. (2010). 313.89 reactive attachment disorder of infancy or early childhood. Retrieved November 22, 2010, from <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=120>
- Baum, N. (2005). Correlates of clients' emotional and behavioral responses to treatment termination. *Clinical Social Work Journal*, 33, 309-326.
- Blount-Matthews, Kirsten M., and Matthew J. Hertenstein. "Attachment." *Encyclopedia of Human Development*. 2005. SAGE Publications. 24 Nov. 2008. <http://sage-reference.com/humandevelopment/Article_n59.html>.
- Brisch, K.H. (2002). *Treating attachment disorders: From theory to therapy*. New York: Guilford.
- Buckner, J. D., Lopez, C., Dunkel, S., & Joiner, T. E. (2008). Behavior management training for the treatment of reactive attachment disorder. *Child Maltreatment*, 13, 289-297.

- Butzer, B. & Campbell, L. (2008). Adult attachment, sexual satisfaction, and relationship satisfaction: A study of married couples. *Personal Relationships*, 15, 141, 148-150.
- Cain, C.S. (2006). *Attachment disorders: Treatment strategies for traumatized children*. Lanham, Maryland: Rowman & Littlefield.
- Drisko, J. W., & Zilberstein, K. (2008). What works in treating reactive attachment disorder: Parents' perspectives. *The Journal of Contemporary Social Services*, 89, 476-486.
- Floyd, K. K., Hester, P., Griffin, H. C., Golden, J., & Smith Canter, L. L. (2008). Reactive attachment disorder: Challenges for early identification and intervention within the schools. *International Journal of Special Education*, 23, 47-55.
- Greenwald, R. (2005). *Child trauma handbook: A guide for helping trauma-exposed children and adolescents*. New York: Haworth Maltreatment and Trauma.
- Hardy, L. T. (2007). Attachment theory and reactive attachment disorder: Theoretical perspective and treatment implications. *Journal of Child and Adolescent Psychiatric Nursing*, 20, 27-39.
- Haugaard, J. & Hazan, C. (2004). Recognizing and treating uncommon behavioral and emotional disorders in children and adolescents who have been severely maltreated: Reactive attachment disorder. *Child Maltreatment*, 9(2), 154-160.
- Hinshaw-Fuselier, S., Heller, S.S., Parton, V.T., Robinson, L., & Boris, N.W. (2002). Trauma and attachment: The case for Disrupted Attachment Disorder. In J.D. Osofsky (Ed.), *Young children and trauma: Intervention and treatment* (pp. 47-68). New York: Guilford.

- Hodges, K. (2000). Child and Adolescent Functional Assessment Scale (CAFAS\Form FAS10). Ann Arbor, MI: Functional Assessment Systems.
- Hoffman, K. T., Marvin, R. S., Cooper, G. & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The Circle of Security intervention. *Journal of Counseling and Clinical Psychology, 74*, 1017-1026.
- Hornor, G. (2008). Reactive attachment disorder. *Journal of Pediatric Health Care, 22*, 234-239.
- Hough, P. (2008). *Investigation of a treatment approach for Reactive Attachment Disorder*. Doctoral dissertation, U Alberta, Canada.
- Kottman, T. (1995). *Partners in play: An Adlerian approach to play therapy*. Alexandria, VA: American Counseling Association.
- Landreth, G. (2002). *Play therapy: The art of the relationship* (Second ed.). New York: Brunner-Routledge.
- Levy, T.M. & Orlans, M. (1998). *Attachment, trauma, and healing: Understanding and Treating Attachment Disorder in Children and Families*. Washington, DC: CWLA Press.
- Macneil, C. A., Hasty, M. K., Conus, P., & Berk, M. (2010). *Acta Neuropsychiatrica, 22*, 43-45.
- Many, M. M. (2009). Termination as a therapeutic intervention when treating children who have experienced multiple losses. *Infant Mental Health Journal, 30*, 23-39.
- Mercer, J., Sarner, L., Rosa, L., with a chapter by Costa, G. (2003). *Attachment therapy on trial: The torture and death of Candace Newmaker*. Westport, Connecticut: Praeger.

- Mroz, J. & Rubin, P.B. (2005). Dyadic developmental psychotherapy in practice. In A. Becker-Weidman & D. Shell (Eds.), *Creating capacity for attachment: Dyadic developmental psychotherapy in the treatment of trauma-attachment disorders* (pp. 69-108). Oklahoma City: Wood 'N' Barnes.
- Prior, V. & Glaser, D. (2006). *Understanding attachment and attachment disorders: Theory, evidence and practice*. London: Jessica Kingsley Publishers.
- Randolph, E. M. (2000). Manual for the Randolph Attachment Disorder Questionnaire—RADQ (3rd ed.). Evergreen, CO: Attachment Center Press.
- Shaw, S. R., & Páez, D. (2007). Reactive attachment disorder: Recognition, action, and considerations for school social workers. *Children and Schools*, 29, 69-74.
- Sommers-Flanagan, J. & Sommers-Flanagan, R. (2007). *Tough kids, cool counseling: User-friendly approaches with challenging youth*. Alexandria, VA: American Counseling Association.
- Stafford, B.S., & Zeanah, C.H. (2006). Attachment disorders. In J.L. Luby (Ed.), *Handbook of preschool mental health: Development, disorders, and treatment* (pp. 231-251). New York: Guilford.
- van der Kolk, B. A., Pynoos, R. S., Cicchetti, D., Cloitre, M., D'Andrea, W., Ford, J. D., et al. (2009). Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V. Retrieved November 5, 2010 from http://www.traumacenter.org/announcements/DTD_papers_Oct_09.pdf
- Webster, L. (2005). Reactive attachment disorder of infancy and early childhood. In *Encyclopedia of School Psychology*. Retrieved September 17, 2008 from SAGE Publications.

- Weinfield, N. S., Sroufe, L. A., & Egeland, B. (2000). Attachment from infancy to early adulthood in a high-risk sample: Continuity, discontinuity, and their correlates. *Child Development, 71*, 695-702.
- Weir, K. N. (2007). Using integrative play therapy with adoptive families to treat reactive attachment disorder: A case example. *Journal of Family Psychotherapy, 18*, 1-16.
- Wimmer, J. S., Vonk, M. E., & Bordnick, P. (2009). A preliminary investigation of the effectiveness of attachment therapy for adopted children with reactive attachment disorder. *Child and Adolescent Social Work Journal, 26*, 351-360.
- Wimmer, J. S., Vonk, M. E., & Reeves, P. M. (2010). Adoptive mothers' perceptions of reactive attachment disorder therapy and its impact on family functioning. *Clinical Social Work Journal, 38*, 120-131.
- Zilberstein, K. (2008). Au revoir: An attachment and loss perspective on termination. *Clinical Social Work Journal, 36*, 301-311.

APPENDIX A: ARTICLE MANUSCRIPT

Supervisee: “I’m worried about how I’m going to terminate with Khin.”

Supervisor: “When do you need to end with her?”

Supervisee: “Gosh, not for another five months or so.”

Supervisor: “Then why you are so anxious about it right now?”

This exchange between my supervisor and me, a novice counselor, helped me see how much anxiety I had about saying goodbye to a young client with a diagnosis of reactive attachment disorder (RAD). I had been working with Khin (the client’s name has been changed to protect confidentiality) for several months and had grown very fond of the six-year-old girl. She originally could not manage her behavior in kindergarten because of her RAD which stemmed from an abrupt change in her caregiver. She was very sweet, seemed to yearn for meaningful relationships, including with me, and she was making progress in counseling. Therefore there was a major factor besides my inexperience that compelled me to worry about termination. Because Khin was diagnosed with reactive attachment disorder, I was afraid that ending our therapeutic relationship would do further harm to her. The diagnosis loomed large in my mind. It was something that made Khin different than other young clients I worked with, and something that made me doubt my therapeutic instincts and skills. Specifically, because her attachment disorder stemmed mostly from a sudden change in caregiver, the closer Khin and I became, the more afraid I was of ending our relationship. Termination became a frightening process in the future.

Months later when the time to terminate did arrive, I felt more confident because of the consultation and supervision I received from attachment specialist co-workers.

That successful termination left me interested in the best practices for terminating with child clients who are diagnosed with reactive attachment disorder. Since then I have reviewed relevant literature to learn more on working with clients with RAD diagnoses. This article is informed by that research. It covers background information on RAD and then gives recommendations for terminating with children diagnosed with RAD. Clinical experiences with Khin and other clients also serve as illustrations throughout.

Overview of Reactive Attachment Disorder

Attachment is the organization of behaviors in a child that serve to create closeness with a caregiver in times when the child wants comfort and nurturance (American Academy of Child and Adolescent Psychiatry [AACAP], 2005). The formation of a secure attachment with an adult caretaker is an essential part of a child's healthy development (Hough, 2008). Attachment is key to an individual's mental health because it plays a role in an individual's sense of self and influences an individual's ability to effectively manage emotions and behaviors (AACAP, 2005; Hornor, 2008). John Bowlby is credited as being the first to articulate attachment theory, which suggests that caregiver characteristics support a child's healthy attachment development. These characteristics include stability in environment, sensitivity to the child, and responsiveness to the child's needs (American Professional Society on the Abuse of Children [APSAC], 2006; Hardy, 2007; Blount-Matthews & Hertenstein, 2005).

When emotional needs are not met early in life, and a healthy attachment relationship is not formed, there can be many consequences including difficulty regulating affect and maladaptive behaviors (Hough, 2008). In some cases when children

have weak or disrupted attachments with caregivers, they develop RAD. Reactive attachment disorder is defined in the DSM-IV as “markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years” (APA, 2000, p. 127). The disturbed social relatedness can take on an inhibited or disinhibited form, and must result from pathogenic care. Pathogenic care can take three forms: consistent neglect of physical needs, consistent neglect of emotional needs, or repeated caregiver changes (APA, 2000). It should be noted that the diagnostic criteria for RAD are currently being reviewed for the fifth edition of the Diagnostic and Statistical Manual. One specific criticism of the RAD diagnosis comes from a proposal to add developmental trauma disorder (DTD) as a more comprehensive and accurate way to recognize the effects on children from chronic interpersonal trauma (van der Kolk, et al., 2009). The proposal specifically indicated that while RAD and DTD overlap in many ways, the RAD diagnosis does not address an enduring negative sense of self or the consequences of interpersonal violence. Additionally, the RAD diagnosis does not address the behaviors of affect dysregulation, aggression, self-harm, self-soothing, and risk-taking. However, both diagnoses share the central issue of a severe disruption in caregiving. After a great deal of discussion, DTD is not slated to be included to the new version of the DSM. However, the RAD diagnosis will change significantly in the DSM-V in that it will be split in to two disorders: reactive attachment disorder of infancy and early childhood and disinhibited social engagement disorder (APA, 2010). These modifications of RAD will alter the framework for the diagnosis, however, the importance of successful termination for children meeting the criterion for either of the proposed disorders will continue.

Reactive Attachment Disorder Treatments

While no treatment approach for RAD has been empirically supported (Drisko and Zilberstein, 2008; Stafford and Zeanah, 2006), clinicians have written about several approaches and there are general treatment guidelines for RAD. In broad terms, treatment for RAD can be conducted in three primary formats: a counselor working with a parent, with the child, or with the parent-child dyad. In more specific terms, the literature outlines many approaches to RAD interventions that are typically based in theoretical frameworks. Family systems approaches can examine the family patterns, educate the parents on RAD, and help them practice secure attachment interactions (Levy & Orlans, 1998). Attachment therapy can combine techniques including neurofeedback, narrative therapy, and parenting skills training (Wimmer, Vonk, and Bordnick, 2009). Mroz and Rubin (2005) outline an eight-step approach for working with the caregiver and child and involves identifying a problem behavior, the emotion behind it, and having the parent empathize with the child's emotion. The Circle of Security™ includes psychoeducation and therapy with caregivers to help parents be correctly attuned to their children and to serve as a secure base for children's development (Hoffman, Marvin, Cooper & Powell, 2006). Behavior management training can incorporate psychoeducation, parenting skills, and reward systems to improve the child's behavior (Buckner, Lopez, Dunkel, and Joiner, 2008; Cain, 2006).

The American Professional Society on the Abuse of Children (APSAC) and the American Academy of Child and Adolescent Psychiatry (AACAP) published general recommendations for treating reactive attachment disorder. AACAP favors a dyadic approach because by focusing on the relationship, practitioners address the central

component to the RAD diagnosis (AACAP, 2005). Also among the recommendations are treatments which are “focused, goal-directed, and behavioral” and which attend to parental sensitivity (APSAC, 2006, p. 78). All of the APSAC and AACAP guidelines are to be considered in a context of a treatment plan and not to be taken as the components of an explicit treatment plan.

The interventions outlined above are all recommendations made when considering what is best for clients, and often assume an ideal treatment context. It should be noted, however, that the realities of counseling work often require adjustments. For instance, while working with Khin, I worked for an agency with a structural family therapy approach. Therefore, the goal was to work with Khin and her parents to help Khin develop an attachment relationship. However, because Khin was at an imminent risk of being expelled from kindergarten, that crisis dictated that I work primarily with Khin in the school until her behavior stabilized. The stabilization goals included Khin not hitting, kicking, and spitting at teachers, not running out of the classroom, and reducing fits of crying. The school wanted her to be able to participate in a half day of preschool including a nap and to be able to follow the school rules throughout the day. As a result of these goals, for an extended period of time my focus was in the school before the counseling could shift to Khin and her parents. In the school I helped teachers and administrators understand Khin’s needs, including adjusting her schedule and changing how they responded to problematic behavior. I provided a consistent, non-reactive presence for Khin and helped her develop a healthy attachment relationship with me to help her regulate her affect. I also helped her strengthen specific skills like self-soothing. All of these approaches helped her meet the school’s basic behavior

requirements and helped Khin maintain her placement in the school. Once she was stable in the school, the work could shift to the parent-child interventions. My work with Khin is one example of how multiple factors can complicate therapeutic interventions. Therefore all recommendations, including those in this article, should be considered in the unique treatment context and utilized when appropriate.

There is a second major consideration when applying recommendations in this article. The recommendations described below can be read as interventions for individual counseling with child clients. However, according to AACAP, the least ideal approach for counseling clients with reactive attachment disorder diagnoses is to work with the child alone. As noted above, sometimes the realities of a client's situation dictate that counselors stray from the most recommended practices. Indeed AACAP recognizes one such instance when noting that individual counseling with clients diagnosed with RAD can be appropriate if it reduces the behaviors that interfere with the dyadic counseling (AACAP, 2005). Therefore recommendations for individual counseling with clients diagnosed with RAD is still applicable. It is my intention that most of the recommendations can be applied to the dyadic counseling work with both child and caregiver(s). Readers can consider the degree to which the recommendations can be applied to any given therapeutic approach, including those that involve individual counseling, those that work directly with parents to help children, and those that work with the parent-child dyad.

Macneil, Hasty, Conus and Berk (2010) emphasized that termination is the most important part of therapy for clients who have problematic attachment histories. They pointed out that termination can be an opportunity with such clients. If done well,

termination can give clients the experiential knowledge that endings do not have to be accompanied by profound loss or trauma. Many (2009) also described termination as a therapeutic intervention in itself for such clients. Many recommended helping the child's caregiver form an ending that is predictable and sensitive to the child. If both the child and caregiver experience such a loss that is not traumatic, they will have a new model for how to manage losses in the future. It is my hope that the following recommendations will increase practitioners' abilities to provide such a therapeutic experience when terminating a counseling relationship with a child diagnosed with reactive attachment disorder.

Terminating with Reactive Attachment Disorder Children: Recommendations

With any client, termination has the potential to be a harmful event or to be a therapeutic intervention in itself. This is especially true of children diagnosed with reactive attachment disorder for two main reasons. First, the relationship with the counselor can be a significant attachment relationship for the child. Therefore, losing that significant relationship can re-traumatize the child. Second, the effects can be especially harmful because children diagnosed with RAD often lack skills such as emotional self-regulation that would help them cope with such a change. While there is a lack of literature specifically on recommended practices for terminating with children diagnosed with reactive attachment disorder diagnoses, general termination literature, publications on terminating with children, and those that focus on terminating with children who have experienced trauma and loss were reviewed. Factors particularly

relevant for children diagnosed with RAD were selected and used to generate the following recommendations.

Create Structure

The concept of ending the counseling relationship can be a difficult one for young clients to understand. Providing them with a visual framework can help them understand the process. When I explained to six-year-old Khin the transition from working with me to seeing a new counselor, I used a grid of pictures to illustrate what I was saying. One sheet of paper that I had divided into six boxes, I had stick figure pictures representing the next six sessions. Pictures with one short figure and one tall figure represented the sessions with Khin and myself. One short stick figure and two tall ones were the sessions with Khin, the new counselor, and myself. Khin and I reviewed the pictures and what they meant. Then during each session Khin colored the picture that represented that day. In this way, the visual representation of termination helped me explain the process to Khin, and helped us track our progression in the process.

Facilitate Control

General termination literature indicates that both child and adult clients feel best about termination when they have some control over the process (Baum, 2005). Depending on factors like funding sources and therapeutic appropriateness, counselors might or might not be able to allow a child client to have some control over when counseling ends. Even if counselors aren't able to help clients feel like they have control over *when* counseling ends, counselors are able to help the client have some control over

how counseling ends. One option is to create a calendar to display the number of sessions remaining, taking into consideration the child's age and conception of time. Along with helping the client anticipate the goodbye, the counselor and child can discuss how they wish to 'celebrate' the child's progress and the relationship. Possibilities for allowing clients control over the process of termination include giving clients choices about session length or who else they may wish to invite. All of these options for helping clients have control should be weighed for their therapeutic value and the possible stress to the child for lack of structure or appropriate adult caregiving.

Go about It Gradually

Clients' experiences of termination are also helped when the ending of counseling is not abrupt (Baum, 2005; Landreth, 2002; Many, 2009). Children in general respond well to structure, and children diagnosed with RAD can especially benefit from having a gradual termination process that is well laid-out for them. This is markedly important when a child has developed RAD from a sudden change in caregivers. My fears of terminating with Khin stemmed mostly from the fact that she had such a background. I did not want to be another significant adult in her life who suddenly disappeared (or seemed to). When I terminated with Khin, counseling services were not ending. Instead I was leaving the counseling agency to go to graduate school. Therefore our termination consisted of closing our relationship and a relationship beginning between Khin and the new counselor. One way that I helped the termination process take a gradual pace was to incorporate the new counselor over the course of several sessions and to include a ceremony for our last session.

A common way for the termination of counseling services to be gradual is to taper the sessions. For instance, weekly sessions can shift to every-other-week sessions. Counselors can also set up a small number of check-in sessions to ease the transition, perhaps as much as once a month for a few months.

Encourage Emotional Expression

Termination can be a time of strong emotion for clients, and children diagnosed with RAD might especially benefit from being able to express and process those feelings. In particular, if the counselor reflects the child's emotions, it can help clients with RAD regulate those emotions. Feelings of loss, sadness, and abandonment are examples of normal feelings around losing a relationship (Landreth, 2002; Zilberstein, 2008). However, symptoms can increase when counselors minimize or overemphasize a client's emotions, so it is important to accurately reflect emotions (Zilberstein, 2008). Counselors might need to address clients' feelings of wanting the relationship to continue, especially if the relationship with the counselor has been more positive than past attachment relationships (Sommers-Flanagan & Sommers-Flanagan, 2007).

In addition, there are two problematic paths counselors will benefit from thinking through when trying to help clients. The first is trying to help the client feel better by minimizing the depth of the emotional response to loss. Because difficult emotions are normal with the ending of a significant relationship, it is more helpful to reflect and accept the emotions. Striving to help clients feel better can be a harmful example of minimizing their experience. Second, counselors should beware of sharing their emotional experience with clients diagnosed with RAD. Statements about missing the

client can lead a child to feel guilty and should probably be avoided (Landreth, 2002). If a counselor is considering expressing some of the emotional reaction to the termination, he or she should be clear on what therapeutic purpose it will serve for the client, and should reflect on the best approach for that self-disclosure.

Create Ceremony/Ritual

Including a ceremony, ritual, or party for a final session might help a client diagnosed with RAD transition from having an intensive relationship with a counselor to either saying a final goodbye or ending current counseling services (depending on how final the ending is).

The final session can involve a celebration, often including food and a small present (Many, 2009). Such a celebration may help the child feel like the change is positive and represents a transition rather than solely a loss. When I said goodbye to Khin, the therapy team working with the family organized a goodbye dinner. We shared a meal with the family and took time to exchange bracelets of strings and beads. Each family member had an opportunity to give me a bead and share something he or she would remember about me. I then gave each family member a bead for each bracelet and spoke about something I would remember about them. Such an idea can be easily include anyone who has been participating in counseling, and through the ritual and through creating a transitional object can benefit the client's experience of termination.

Celebrate Success

One recommendation for terminating with child clients is to consistently review the progress they have made while in therapy (Kottman, 1995; Sommers-Flanagan & Sommers-Flanagan, 2007). Clients can benefit when counselors emphasize clients' feelings of pride and accomplishment (Zilberstein, 2008). Hopefully with a client with a diagnosis of reactive attachment disorder, a lot of the progress has been in the parent-child relationship, but that progress probably also includes a significant change in the client's behavior and abilities. Counselors can point out clients' strengthened capacity for self-regulation, or specifics of their improved behavior. Metaphors can be an effective way to highlight success to children. Tree climbing provided a useful metaphor for one client diagnosed with RAD with whom I worked. The elementary-school-age boy loved to climb to great heights in trees. When intensive services were ending, and he was shifting to outpatient counseling, I framed his success as getting so good at climbing on the medium-high braches that he was ready to climb to the next higher level. Another medium for summarizing progress is the goodbye letter. Fitting with the narrative therapy approach, a letter or story written to the client can summarize the course of therapy and emphasize progress made (Macneil, Hasty, Conus and Berk, 2010).

Leave the Door Open

An ideal approach to ending counseling with a child client is to end with an open door approach (Sommers-Flanagan & Sommers-Flanagan, 2007). It is particularly true for clients diagnosed with RAD, because rage, anger and anxiety can occur when they feel like they cannot return to see their counselors. Therefore, planning the termination to

include check-in sessions can greatly ease the child's reaction to the termination process (Zilberstein, 2008). Such an approach is not always available depending on the counseling setting and funding source. This approach might be easier to do in private practice than when working for an agency. However, it could be helpful for any counselor to consider to what degree it might be an option.

Summary

RAD presents unique challenge and opportunity to counselors at the time of termination. Ending a therapeutic relationship with children diagnosed with reactive attachment disorder requires particular consideration and planning for two main reasons. Losing a significant relationship has the potential to re-traumatize the child, and children diagnosed with RAD often lack skills which help them cope with the change. Counselors from different theoretical approaches may find it useful to weigh the recommendations described here, to consider the clinical reasoning behind them, and to decide which to incorporate in to their termination process.

REFERENCES

- American Academy of Child and Adolescent Psychiatry. (2005). Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 1206-1219.
- American Professional Society on the Abuse of Children. (2006). Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment*, 11, 76-89.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., rev). Washington, DC: Author.
- American Psychiatric Association. (2010). 313.89 reactive attachment disorder of infancy or early childhood. Retrieved November 22, 2010, from <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=120>
- Baum, N. (2005). Correlates of clients' emotional and behavioral responses to treatment termination. *Clinical Social Work Journal*, 33, 309-326.
- Blount-Matthews, Kirsten M., and Matthew J. Hertenstein. "Attachment." *Encyclopedia of Human Development*. 2005. SAGE Publications. 24 Nov. 2008. <http://sage-reference.com/humandevelopment/Article_n59.html>.
- Buckner, J. D., Lopez, C., Dunkel, S., & Joiner, T. E. (2008). Behavior management training for the treatment of reactive attachment disorder. *Child Maltreatment*, 13, 289-297.
- Cain, C.S. (2006). *Attachment disorders: Treatment strategies for traumatized children*. Lanham, Maryland: Rowman & Littlefield.

- Drisko, J. W., & Zilberstein, K. (2008). What works in treating reactive attachment disorder: Parents' perspectives. *The Journal of Contemporary Social Services, 89*, 476-486.
- Hardy, L. T. (2007). Attachment theory and reactive attachment disorder: Theoretical perspective and treatment implications. *Journal of Child and Adolescent Psychiatric Nursing, 20*, 27-39.
- Hoffman, K. T., Marvin, R. S., Cooper, G. & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The Circle of Security intervention. *Journal of Counseling and Clinical Psychology, 74*, 1017-1026.
- Honor, G. (2008). Reactive attachment disorder. *Journal of Pediatric Health Care, 22*, 234-239.
- Hough, P. (2008). *Investigation of a treatment approach for Reactive Attachment Disorder*. Doctoral dissertation, U Alberta, Canada.
- Kottman, T. (1995). *Partners in play: An Adlerian approach to play therapy*. Alexandria, VA: American Counseling Association.
- Landreth, G. (2002). *Play therapy: The art of the relationship* (Second ed.). New York: Brunner-Routledge.
- Levy, T.M. & Orlans, M. (1998). *Attachment, trauma, and healing: Understanding and Treating Attachment Disorder in Children and Families*. Washington, DC: CWLA Press.
- Macneil, C. A., Hasty, M. K., Conus, P., & Berk, M. (2010). *Acta Neuropsychiatrica, 22*, 43-45.

- Many, M. M. (2009). Termination as a therapeutic intervention when treating children who have experienced multiple losses. *Infant Mental Health Journal, 30*, 23-39.
- Mroz, J. & Rubin, P.B. (2005). Dyadic developmental psychotherapy in practice. In A. Becker-Weidman & D. Shell (Eds.), *Creating capacity for attachment: Dyadic developmental psychotherapy in the treatment of trauma-attachment disorders* (pp. 69-108). Oklahoma City: Wood 'N' Barnes.
- Sommers-Flanagan, J. & Sommers-Flanagan, R. (2007). *Tough kids, cool counseling: User-friendly approaches with challenging youth*. Alexandria, VA: American Counseling Association.
- Stafford, B.S., & Zeanah, C.H. (2006). Attachment disorders. In J.L. Luby (Ed.), *Handbook of preschool mental health: Development, disorders, and treatment* (pp. 231-251). New York: Guilford.
- van der Kolk, B. A., Pynoos, R. S., Cicchetti, D., Cloitre, M., D'Andrea, W., Ford, J. D., et al. (2009). Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V. Retrieved November 5, 2010 from http://www.traumacenter.org/announcements/DTD_papers_Oct_09.pdf
- Wimmer, J. S., Vonk, M. E., & Bordnick, P. (2009). A preliminary investigation of the effectiveness of attachment therapy for adopted children with reactive attachment disorder. *Child and Adolescent Social Work Journal, 26*, 351-360.
- Zilberstein, K. (2008). Au revoir: An attachment and loss perspective on termination. *Clinical Social Work Journal, 36*, 301-311.