



Complete Summary

GUIDELINE TITLE

Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Child and Adolescent Psychiatry (AACAP). Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood. Washington (DC): American Academy of Child and Adolescent Psychiatry (AACAP); 2005. 24 p. [101 references]

GUIDELINE STATUS

This is the current release of the guideline.

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SCOPE

DISEASE/CONDITION(S)

Reactive attachment disorder including:

- Emotionally withdrawn/inhibited pattern
- Indiscriminate/uninhibited pattern

GUIDELINE CATEGORY

Diagnosis
Evaluation
Treatment

CLINICAL SPECIALTY

Family Practice
Pediatrics
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

To review the current status of reactive attachment disorder with regard to assessment and treatment

TARGET POPULATION

Children and adolescents with reactive attachment disorder

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment

1. Serial observations of the child interacting with his or her primary caregivers and unfamiliar adults using a relatively structured observational paradigm
2. Comprehensive history of the child's early caregiving environment, including from collateral sources (e.g., pediatricians, teachers, or caseworkers)
3. Reporting of any suspicion of previously unreported or current maltreatment to the appropriate law enforcement and protective authorities
4. Referral to a developmental and/or speech specialist and medical screening, if indicated
5. Assessment of the caregiver's attitudes toward the child and perceptions about the child

Treatment

1. Ensuring that the child is in a safe and stable environment
2. Creating positive interactions with caregivers
3. Adjunctive treatment for comorbidities, if indicated

Note: Interventions involving noncontingent physical restraint or coercion (e.g., "therapeutic holding" or "compression holding"), "reworking" of trauma (e.g., "rebirthing therapy"), or promotion of regression for "reattachment" have no empirical support and have been associated with serious harm, including death, and therefore, are not recommended.

MAJOR OUTCOMES CONSIDERED

- Risk factors for development of reactive attachment disorder (RAD)
- Prevalence of RAD

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The list of references for this practice parameter was developed by searches of *Medline* and *Psychological Abstracts*, by reviewing bibliographies of book chapters and review articles, and by asking colleagues for suggested source materials. A *Medline* search of articles published since 1980 was conducted and updated through March of 2003 and yielded 45 references. A search of *PSYCInfo* for articles published since 1980, also conducted through March 2003, yielded 49 references. A more extended search of related articles yielded another 456 references. In addition, searches of relevant publications by the following authors were conducted because of their expertise in this area: Neil W. Boris, Kim Chisholm, Patricia Crittenden, Mary Dozier, Alicia Lieberman, Mary Main, Thomas O'Connor, Michael Rutter, Anna Smyke, Marinus van IJzendoorn, and Charles H. Zeanah. Search words included reactive attachment disorder, disinhibited attachment, and attachment disorders in childhood.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The validity of scientific findings was judged by design, sample selection and size, inclusion of comparison groups, generalizability, and agreement with other studies.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Clinical consensus was determined through extensive review by the members of the Work Group on Quality Issues, child and adolescent psychiatry consultants with expertise in the content area, the entire Academy membership, and the Academy Assembly and Council.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

[MS] "Minimal Standards" are recommendations that are based on substantial empirical evidence (such as well controlled, double-blind trials) or overwhelming clinical consensus. Minimal standards are expected to apply more than 95 percent of the time (i.e., in almost all cases). When the practitioner does not follow this standard in a particular case, the medical record should indicate the reason.

[CG] "Clinical Guidelines" are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75 percent of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

[OP] "Options" are practices that are acceptable, but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases they may be the perfect thing to do, but in other cases should be avoided. If possible, the practice parameter will explain the pros and cons of these options.

[NE] "Not Endorsed" refers to practices that are known to be ineffective or contraindicated.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This parameter was reviewed at the member forum at the 2003 annual meeting of the American Academy of Child and Adolescent Psychiatry (AACAP).

During October to December 2004 a consensus group reviewed and finalized the content of this practice parameter. The consensus group consisted of representatives of relevant AACAP components as well as independent experts.

This practice parameter was approved by AACAP Council on February 1, 2005.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations are identified as falling into one of four categories of endorsement. These categories (MS, CG, OP, NE), which are defined at the end of the "Major Recommendations" field, indicate the degree of importance or certainty of each recommendation.

1. The assessment of reactive attachment disorder (RAD) requires evidence directly obtained from serial observations of the child interacting with his or her primary caregivers and history (as available) of the child's patterns of attachment behavior with these caregivers. Observations of the child's behavior with unfamiliar adults are also necessary for diagnosis. Given the association between a diagnosis of RAD and a history of maltreatment, the clinician should also gather a comprehensive history of the child's early caregiving environment, including from collateral sources (e.g., pediatricians, teachers, or caseworkers familiar with the child) [**MS**].
2. A relatively structured observational paradigm should be conducted so that comparable behavioral observations can be established across relationships [**CG**].
3. After assessment, any suspicion of previously unreported or current maltreatment requires reporting to the appropriate law enforcement and protective services authorities [**MS**].
4. Maltreated children are at high risk for developmental delays, speech and language deficits or disorders, and untreated medical conditions. Referral for developmental, speech, and medical screening may be indicated [**CG**].
5. The most important intervention for young children diagnosed with reactive attachment disorder and who lack an attachment to a discriminated caregiver is for the clinician to advocate for providing the child with an emotionally available attachment figure [**MS**].
6. Although the diagnosis of reactive attachment disorder is based on symptoms displayed by the child, assessing the caregiver's attitudes toward and perceptions about the child is important for treatment selection [**CG**].
7. Children with reactive attachment disorder are presumed to have grossly disturbed internal models for relating to others. After ensuring that the child is in a safe and stable placement, effective attachment treatment must focus on creating positive interactions with caregivers [**MS**].
8. Children who meet criteria for reactive attachment disorder and who display aggressive and oppositional behavior require adjunctive treatments [**CG**].
9. Interventions designed to enhance attachment that involve noncontingent physical restraint or coercion (e.g., "therapeutic holding" or "compression holding"), "reworking" of trauma (e.g., "rebirthing therapy"), or promotion of regression for "reattachment" have no empirical support and have been associated with serious harm, including death [**NE**].

Definitions

[**MS**] "Minimal Standards" are recommendations that are based on substantial empirical evidence (such as well controlled, double-blind trials) or overwhelming clinical consensus. Minimal standards are expected to apply more than 95 percent of the time (i.e., in almost all cases). When the practitioner does not follow this standard in a particular case, the medical record should indicate the reason.

[**CG**] "Clinical Guidelines" are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75 percent of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

[**OP**] "Options" are practices that are acceptable, but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases they may be the perfect thing to do, but in other cases they should be avoided. If possible, the practice parameter will explain the pros and cons of these options.

[**NE**] "Not Endorsed" refers to practices that are known to be ineffective or contraindicated.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Practice parameters are strategies for patient management, developed to assist clinicians in psychiatric decision-making. These parameters, based on evaluation of the scientific literature and relevant clinical consensus, describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These parameters are not intended to define the standard of care; nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The clinician--after considering all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources--must make the ultimate judgment regarding the care of a particular patient.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Child and Adolescent Psychiatry

GUIDELINE COMMITTEE

Work Group on Quality Issues

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

This parameter was developed by:

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format from the [American Academy of Adolescent and Child Psychiatry \(AACAP\) Web site](#).

A CD-ROM containing all parameters is available for a fee. See the [AACAP Publication Store](#) for more information.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on May 16, 2005.

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