REACTIVE ATTACHMENT DISORDER

DEBRA WESSELMANN, MS LIMHP
DEBRAWESSELMANN.COM

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Let's consider optimal development to start

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Attachment Security

A sensitive, attuned, and responsive attachment figure in a safe, predictable environment = an infant who trusts, who is easily soothed, who takes guidance, whose nervous system is regulated and well-developed

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Secure Attachment and the "Prefrontal Brain"

The prefrontal brain develops to its potential with an attuned, nurturing attachment relationship for optimal development. Repeated soothing and comforting from the parent increases the number of brain cells in the baby's prefrontal brain.

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Prefrontal brain functioning:

- Responsible for focus, problem-solving, reasoning, cause and effect thinking, impulse control, delayed gratification, memory and learning
- Modulates the automatic "fight-flight" responses generated from the "downstairs brain."
- Functions as "Grand Central Station" to the rest of the brain

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Secure attachment = wider window of tolerance

(Reference: Siegel, 2010; Odgen & Minton, 2000; Deb Dana, Stephen Porges, 2018)

Sympathetic activation (picking up cues of danger)
Fight or flight, frozen, or "fawning" behavior

Wide window of Tolerance

Ventral vagal activation (picking up cues of safety)
Child seeks soothing and can do some self- soothing, engaged social engagement system.

Hypo-arousal (picking up cues of danger)
Flat affect, numb, dissociated, collapsed, slowed, feeling "dead," psychomotor retardation.

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Secure attachment leads to positive beliefs about self, others, and the world:

- I belong.
- I can ask for help.
- I can depend on others.
- It's safe to trust.
- It's safe to love.
- My feelings are OK.
- I am safe.
- I am lovable.
- It's safe to be vulnerable
- The world is good overall.

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Secure attachment leads to optimal social, emotional, and cognitive development

Because secure attachment relationships promote healthy brain and psychological development, the child is able to move through developmental stages in a timely fashion.

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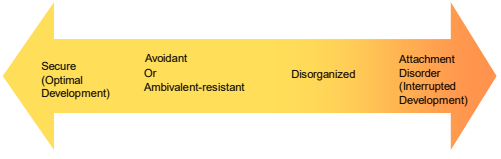
Attachment security-insecurity is on a continuum



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Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) of the American Psychiatric Association

RAD is now listed under Trauma and Stressor-Related Disorders:

Posttraumatic Stress Disorder (309.81)

Disinhibited Social Engagement Disorder (313.89)

Reactive Attachment Disorder (313.89)

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Posttraumatic Stress Disorder DSMV

- Recurrent distressing dreams related to the event
- Persistent attempts to avoid memories and triggers
- Persistent negative thoughts, moods
- Dissociative episodes (i.e. feel dreamlike, out-of-body, etc.)
- Cognitive distortions
- Hypervigilance/hyperarousal/problems with concentration
- Recurrent intrusive memories
- Anger outbursts, self-destructive behaviors, sleep problems, or hypervigilance

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Disinhibited Social Engagement Disorder

- Extremes of insufficient care
- Overly familiar and affectionate with strangers – may even be willing to go off with strangers

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Reactive Attachment Disorder

Consistent pattern of inhibited, emotionally withdrawn behavior toward caregivers, characterized by rarely seeking or responding to comfort when distressed.

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Reactive Attachment Disorder of Infancy and Early Childhood

Insufficient early care, such as severe neglect or repeated changes in caregivers.

The symptoms must appear before age five, be present in children at least nine months old, and not be attributable to other conditions like autism spectrum disorder.

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Reactive Attachment Disorder of Infancy and Early Childhood

- Unexplained irritability, sadness, or fearfulness in social interactions
- A lack of positive emotions
- Difficulty forming healthy relationships.
- May exhibit a desire to control situations, developmental delays, and other behavioral issues

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"Insufficient early care" = Adverse experiences, or "little t" and "Big T" trauma

- Traumatic early attachment experiences are stored in an unprocessed form within memory networks
- Feelings and perceptions related to the early traumas are easily activated, leading to mistrust and reactivity in present-day relationships

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Common traumatic situations that impact trust and attachment throughout childhood:

- early neglect, rejection, or abuse
- parental substance abuse or mental illness
- domestic violence
- painful medical conditions/interventions
- attachment separations/losses

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Emotions and sensations related to preverbal trauma can have strong impact on development

- Difficult birth
- Preterm birth
- Early hospitalization
- Early medical procedures
- Illness in the infant or mother
- Separations from mother
- Early abuse or neglect

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Trauma within early relationship interrupts developmental pathways

- Multiple traumas during developmental years
- Delayed social, emotional, sensorimotor, and cognitive development
- Poor self-regulation. Poor impulse control. Aggression. Reactivity. Hyperarousal.
- Dissociation. Quick changes in affect state.
- Poor sense of self. Distrust. Suspiciousness. Poor interpersonal relationships.
- Flashbacks. Nightmares.
- Attentional problems.

Developmental Trauma Disorder Diagnosis has been proposed by Bessel van der Kolk and Julian Ford

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Trauma and brain functioning/chemistry

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Maltreatment Changes Function and Structure in the Brain (Teicher & Samson, 2016)

- Changes in hormones and neurotransmitters
- Smaller prefrontal brain development
- Cerebellar abnormalities (associated with ADHD, bipolar disorder, schizophrenia, depression, and ADHD)

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Maltreatment changes function and structure in the brain (Continued)

- Smaller corpus callosum (associated with ADHD and bipolar disorder)
- Adult hippocampus (abnormalities associated with PTSD, depression, schizophrenia, bipolar, and BPD)
- Changes in amygdala (associated with enhanced reactivity to emotional faces, PTSD and social phobia, depression, drug addiction, BPD, and schizophrenia)

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Additional common complications

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Attentional Deficit Hyperactivity Disorder (DSMV)

Attentional Problems

- Details
- Focus
- Listening
- Following through
- Organizing
- Sustaining effort
- Losing things
- Distracted
- Forgetful

Hyperactivity Problems

- Fidgets
- Leaves seat
- Runs/climbs when inappropriate
- Unable to play quietly
- Talks excessively
- Blurts answers
- Can't wait
- Interrupts

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Autism Spectrum

- Deficits in social communication and interaction
- Repetitive movements
- Inflexibility
- Fixated interests
- Hyper- or hyporeactivity to sensory input

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Bipolar Disorder and Related Disorders (DSMV)

- Severe depression plus manic or hypomanic episodes or "mixed" episodes.
- Symptoms severe enough that they impair functioning
- Mania: Gambling or other antisocial behaviors, threatening behavior, delusional symptoms, assaultive or suicidal behavior may accompany a manic episode. Loss of judgment, loss of insight, hyperactivity are common.

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Other assaults to the developing brain

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Hidden Head Injuries

- Examples: Shaken or hit in the head as a child
- Long-term effects: Mood swings, aggression, and impaired cognitive functioning

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Additional complications due to prenatal substance exposure

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Alcohol is the most toxic to the unborn child of all the substances that mothers may ingest. With Fetal Alcohol Spectrum Disorder (FASD):

- The brain is physically smaller.
- IQ is lower on average, although some kids' IQ is fine.
- The prefrontal brain may be vastly underdeveloped and lacking the rich network of connections needed to manage impulses, tolerate frustration, think logically, make plans, solve problems, and anticipate outcomes.

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What do we notice in kids with FASD?

- Behaves like a younger child.
- Confabulation (looks like lying).
- Remembers something one day, forgets it the next
- Lacks grasp of deeper meaning
- Can't pay attention
- Impulsive actions
- Lacks understanding of personal space or ownership
- Sexual reactivity common
- Unable to foresee consequences to actions
- Unable to reflect on internal emotions of self or other

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Fetal Alcohol Syndrome (FAS)

- Kids with FAS may have been exposed during any part of pregnancy, but kids with FAS have likely been exposed during week 7 and week 12 and have facial and other physical differences.
- IQ average is lower than that of kids with FASD and no physical features.
- There is evidence that behaviors and other secondary symptoms are often less severe in the case of FAS because adults recognize the disorder and adjust their expectations accordingly.

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Other substances in utero

Tobacco exposure - restricted growth, impulsivity, behavior problems
Opiates - attentional problems, hyperactivity, memory problems
Marijuana exposure - attentional problems, hyperactivity, problem-solving problems
Cocaine exposure - attentional, behavioral, visual-motor, working memory problems
Amphetamine exposure - behaviors problems and social problems
Polysubstance exposure - increases severity of problems
(Behnke & Smith, 2013; Richardson et al., 2008)

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- Adopted/foster kids have high rates of prenatal substance exposure. The majority are properly diagnosed (Chasnoff, 2015).
- Frequently little to no prenatal information.
- Web-based screening tool developed at San Diego University can be utilized: **fasdunited.org/brain-online/**

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Adverse Childhood Experiences (ACE) Study (Felitti, et al., 1998). 10 Categories of Adverse Experiences

Assessment completed by 13,494 Adult Subjects
4 or more adverse experiences lead to high risk of early death

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4 or More Categories of Adverse Events=

- 4 to 12 xs the risk for alcoholism, drug abuse, depression, & suicide attempt
- 2 to 4 xs risk for smoking, poor health, over 50 sexual partners and sexually transmitted disease
- 1.4to 1.6 xs risk for severe obesity
- Graded relationship to ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease

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Trauma within early attachment relationships leads to negative beliefs about self, others, and the world:

- The adults are against me.
- I can't trust them.
- I must keep protective walls.
- It's not safe to be vulnerable.
- I'm bad and don't deserve love.
- I have to take what I need.
- I have to fight to get connection.
- I can't let myself be close.
- I'm shameful.
- I don't belong.
- I'm not important.
- I'm not safe.
- Bad things always happen to me.
- I have to be in charge to stay safe.

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These beliefs are not a choice.

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Negative beliefs lead to self-defeating behaviors

- IF parents/caregivers will always abandon/reject me → THEN I will push them away so I won't get hurt
- IF I can't trust others to take care of me → THEN I have to fend for myself/take what I need/fight or run to survive
- IF I'm bad/unlovable → THEN I will never be good enough and I must not even try
- IF I don't belong/I don't deserve others → THEN I shut down my needs for closeness so it doesn't hurt to be alone

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Examples of Attachment Trauma Triggers

Situations involving…

- Separations from significant others
- Criticism
- Authority figures
- Getting emotionally close to a significant other
- Conflict
- Feeling invalidated
- Not feeling in control
- Losses

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The Survival Response

- Emotional and behavioral dysregulation is protective.
- These behaviors are all part of the fight-flight-freeze response: Nature's way of helping us survive a threatening environment.

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The defensive system doesn't know It's over because the memory remains in unprocessed form

Trauma stored in unprocessed form holds perceptions and feelings present at the time of the trauma in raw form. When triggered, the past feels like the present. The sense of danger may be present ongoing.

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A punitive environment leads to increased symptoms

Punitive approach reinforces the survival mechanisms at work and core negative beliefs: "I can't trust," "I'm all alone," "I have to protect myself," "I'm not safe," "I don't belong, "I'm bad/stupid."

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Problematic attachment patterns
(stored, unprocessed adverse experiences) narrows windows

Sympathetic Activation
Fight or flight, frozen but activated, or "fawning" behavior.

Narrow window of tolerance

Inability to seek comfort. Little engagement of ventral vagal/social engagement system. It's not safe to feel safe.

Dorsal Vagal
Flat affect, numb, dissociated, collapsed, slowed, feeling "dead," psychomotor retardation.

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Dissociation self-protects

- **Non-realization: "It's not real."**
  - Seems like a dream
  - Memory is foggy, confused
  - Denial – "Not that bad"
  - Partial amnesia to full amnesia
- **De-Personification: "It wasn't me."**
  - That did not happen to me.
  - That was not my body.
  - Creation of another part of self to have the memory and own the experience.

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Dissociation is on a Continuum

Low end = regressive tendencies or slight dissociation when triggered.

High end = Strong dissociative barriers, distinct parts of self that take executive control.

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Intervening with RAD children early involves…

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Interventions at all ages requires:

1. Viewing the youth's behaviors through trauma/attachment lens
2. Approaching the youth from a mentalizing state (reflective, non-reactive, listening)
3. Providing secure-based responses to disordered behaviors

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Let's consider some of the common behaviors

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Lying

Beliefs: "I have to protect myself." "I can't trust others to be on my side." "I have to lie to get affection/love/protection."

The lies serve as self-protection due to:

Fear of punishments or rejection

Mental disorganization related to traumatic past

Secure-based response:

"I can sense that it's hard to trust me enough to tell the whole truth. I think if we can talk about this, though, we can find some ways to help with this problem."

Citation: Wesselmann, D. (2025). Attachment Trauma in Kids: Integrative Strategies for Parents. W.W. Norton

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Arguing

Beliefs:

"I can't trust the intentions of adults. I have to be in control to be safe. I have to keep up a protective wall."

The arguments serve as self-protection:

child/teen doesn't trust information from the adult

child/teen perceives the adult as having negative intentions

Secure-based response:

"I can understand if it feels hard to trust. You've been through a lot. I hope you can come to believe that I'm on your side."

Citation: Wesselmann, D. (2025). Attachment Trauma in Kids: Integrative Strategies for Parents. W.W. Norton

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Stealing

Beliefs:

"I can't trust you to take care of me. I have to find a way to get whatever I need or want."

The stealing serves as self-protection:

Feels safer to be in charge of taking what the child/teen needs

Relief from anxiety and sadness

Relationships don't provide comfort or security

Secure-based response:

"I'm wondering if taking that helped you feel better in some way. I want to understand more."

Citation: Wesselmann, D. (2025). Attachment Trauma in Kids: Integrative Strategies for Parents. W.W. Norton

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Aggression

Beliefs:

"I have to protect myself. Others' intentions are dangerous. I need a wall to protect myself."

Aggression is a self-protective response to nervous system activation:

Fight response is an automatic survival response of the nervous system.

Secure-based response:

"I'm here to help. I want to understand." (Calm voice, non-threatening posture, giving space but not abandoning the child/teen)

Citation: Wesselmann, D. (2025). Attachment Trauma in Kids: Integrative Strategies for Parents. W.W. Norton

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Sexualized behaviors (very common in the case of fetal alcohol exposure)

Beliefs:

"I have to act on the urge. I need this to feel safe/connected/pleasure/wholeness."

Sexualized behaviors are often an automatic survival response:

It may be the only touch/body pleasure the child/teen knows.

Secure-based response:

"This has to do with things that happened to you in the past. We'll work together along with your therapist and make a plan so everyone can be safe."

Citation: Wesselmann, D. (2025). Attachment Trauma in Kids: Integrative Strategies for Parents. W.W. Norton

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Bathroom issues

- Enuresis
- Encopresis
- Hiding wet underwear
- Going to the bathroom in odd places
- Feces smearing
- Not wiping
- Leaving a mess

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Bathroom issues

Younger part of child/teen believes: "I can't trust my body. I can't stay in my body. My body and my body functions are the enemy. My body and body functions are bad." child/teen may be operating from a regressed, dissociated state.

The bathroom issues are driven by stored attachment trauma:

The child/teen may have missed the attachment experiences needed to develop capacity to manage body functions.

The child/teen may be dissociated from his body sensations.

The child/teen may be operating out of a much younger, regressed state.

Secure-based response:

"We can all work together to figure out what's happening and to help you."

Citation: Wesselmann, D. (2025). Attachment Trauma in Kids: Integrative Strategies for Parents. W.W. Norton

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Food issues

Younger part of child/teen believes:

"I can't trust grown-ups to provide my body with what it needs to feel safe/pleasure/satisfaction. I have to be in charge of getting what I need." "I won't have enough. I will be hungry."

The food is self-protection:

Food may equal safety and relief. child/teen may have stored memories of being deprived of enough food.

Secure-based response:

"I wonder if food gives some instant good feelings. And I wonder if there are worries about not having food. I want to understand more about that. I want you to feel safe and have what you need."

Citation: Wesselmann, D. (2025). Attachment Trauma in Kids: Integrative Strategies for Parents. W.W. Norton

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Collaborative Proactive Solutions for problem behaviors (Ross Greene, "The Explosive child/teen")

- Ask child/teen, "What is getting in the way of not achieving (desired behavior)?"
- Active listening to child/teen's complaints and feelings.
- Adult says, "Here is my concern…"
- Adult says, "Let's work together to figure out a way to solve the problem."

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Evidence-Based Trauma Interventions

- Trauma-focused Cognitive Behavioral Therapy (TF-CBT) trauma treatment
- Eye Movement Desensitization and Reprocessing (EMDR) trauma treatment

(Over 50 randomized controlled studies, 10 randomized controlled studies with children, support the effectiveness of EMDR. Recommended by WHO, SAMSHA, The California Clearinghouse for Evidence-Based Treatments for Children, ISSTD, and other organizations around the world)

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EMDR and Family Therapy Intervention

- EMDR Integrative Attachment Trauma Protocol for Children and Teens (IATP-C)
  - EMDR and family therapy model for reducing behaviors, improving attachments, and improving traumatic stress.

Wesselmann, D., Armstrong, S., Schweitzer, C., Davidson, M., & Potter, A. (2018). An integrative EMDR and family therapy model for treating attachment trauma in children: A case series. *Journal of EMDR Practice and Research, 12*(4) 196-207.
Wesselmann, D. (2025). EMDR and Family Therapy: Integrative Treatment for Attachment Trauma in Children, 2nd Edition. W.W. Norton.

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Additional mental health interventions

- Family Therapy
- Dialectical Behavioral Therapy (DBT) skills training for personality disorders and those with maladaptive behaviors
- Cognitive Behavioral Therapy (CBT) for restructuring negative beliefs
- Substance Abuse Treatment and Dual Diagnosis Treatment
- Appropriate medications

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- Appropriate interventions, environment, and medications over time can improve trust, capacity to connect, and self-regulation

INTERVENTIONS =

IMPROVED BEHAVIORS, SYMPTOMS, AND INTERPERSONAL FUNCTIONING

TRANSMISSION OF HEALTHIER ATTACHMENT PATTERNS TO THE NEXT GENERATION

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- Thank you!

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