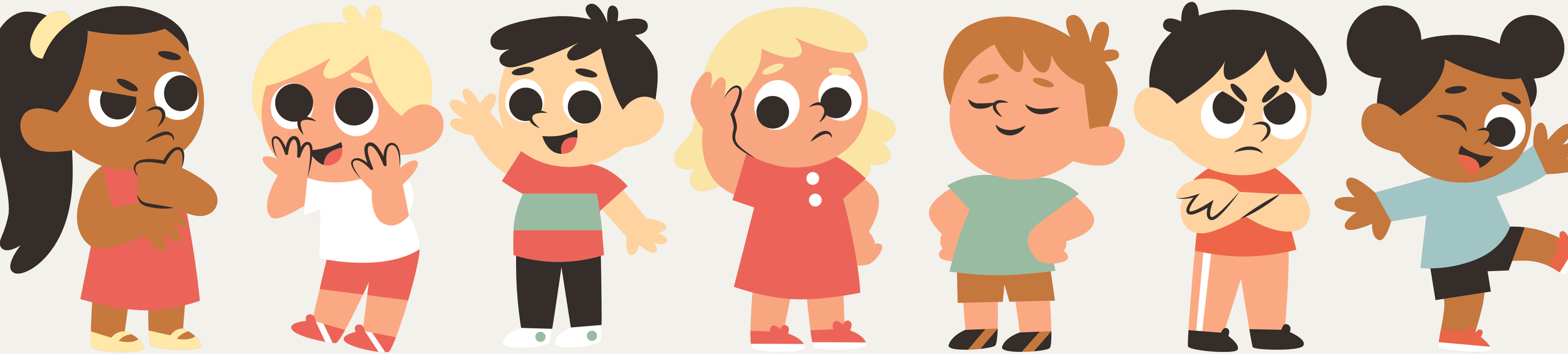
Redefining

RAD



CHECK IN

WHAT ROLE ARE YOU SHOWING UP IN TODAY ?

WHAT DO YOU HOPE TO TAKE AWAY?

Rebecca Davis

- Born, grew up and raised my own kids in Alaska.
- Specialize in Children and Families
- LCSW
- Attachment lens
- Worked in child welfare, Juvenile Justice, Early Intervention, Therapy
- Adopted daughter
- Got some things wrong as a mom
- Believe everyone can heal

AGENDA

INTRODUCTIONS

ATTACHMENT

RECOGNIZING THE NEED FOR HELP

DIAGNOSIS

DEVELOPMENTAL TRAUMA

NEUROPLASTICITY

STRATEGIES

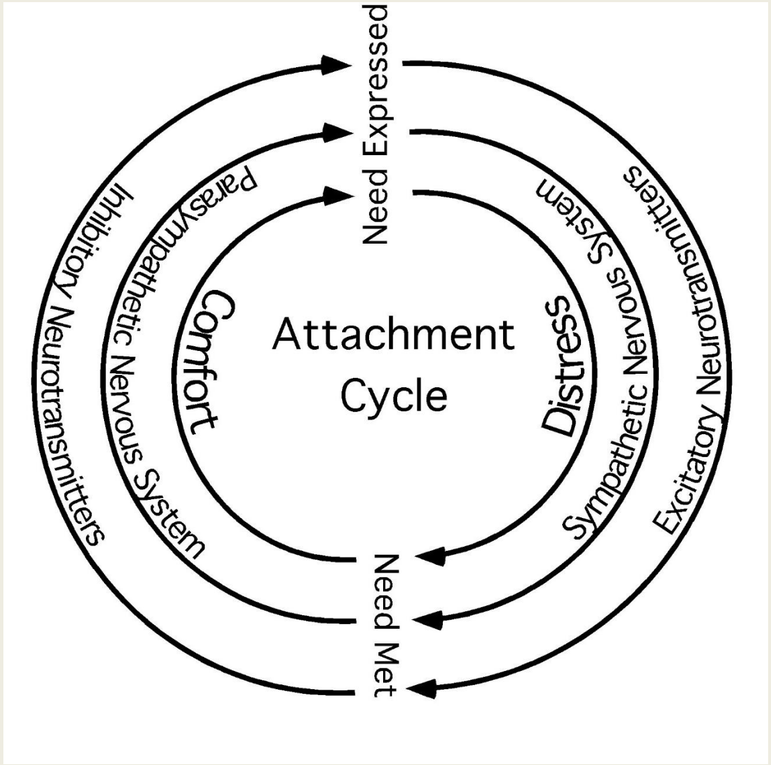
BOWLBY'S 3 ATTACHMENT BEHAVIORS

They seek, monitor, and maintain proximity to caregiver.

They use their attachment figure as a secure base

They flee to caregiver when they are afraid.

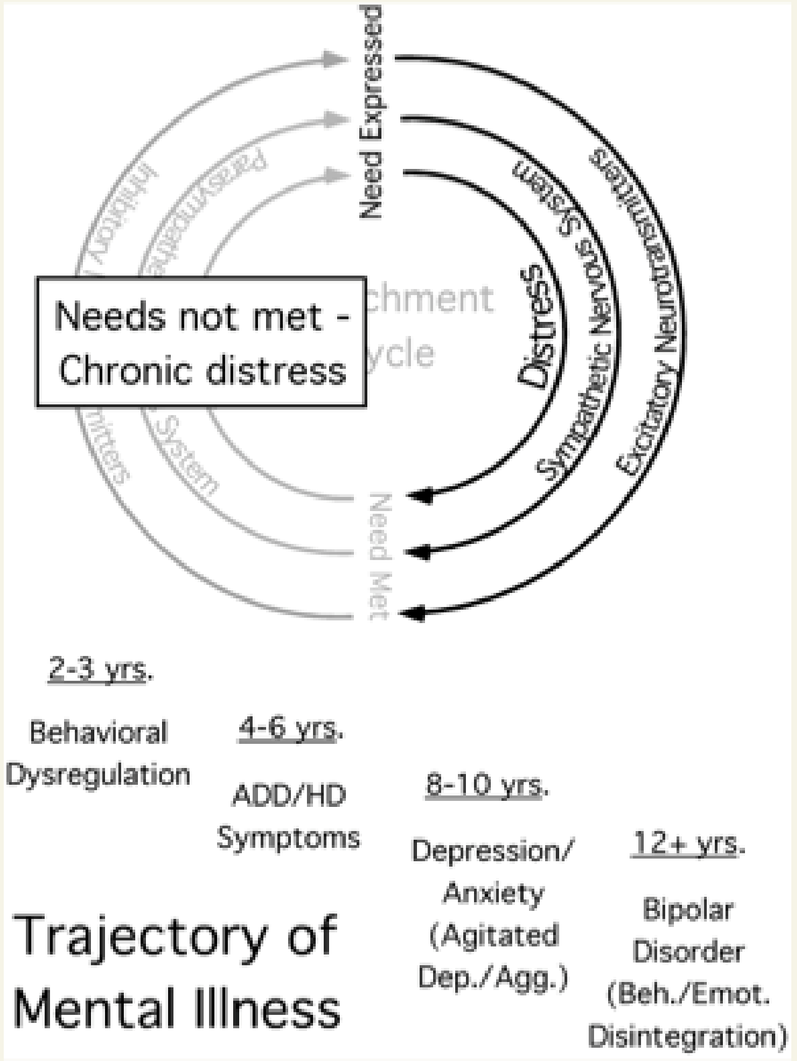
The Attachment Cycle



Foundation for:

Trust
Self-worth
Self-efficacy (voice)
Self-regulation
Mental health

TBRI

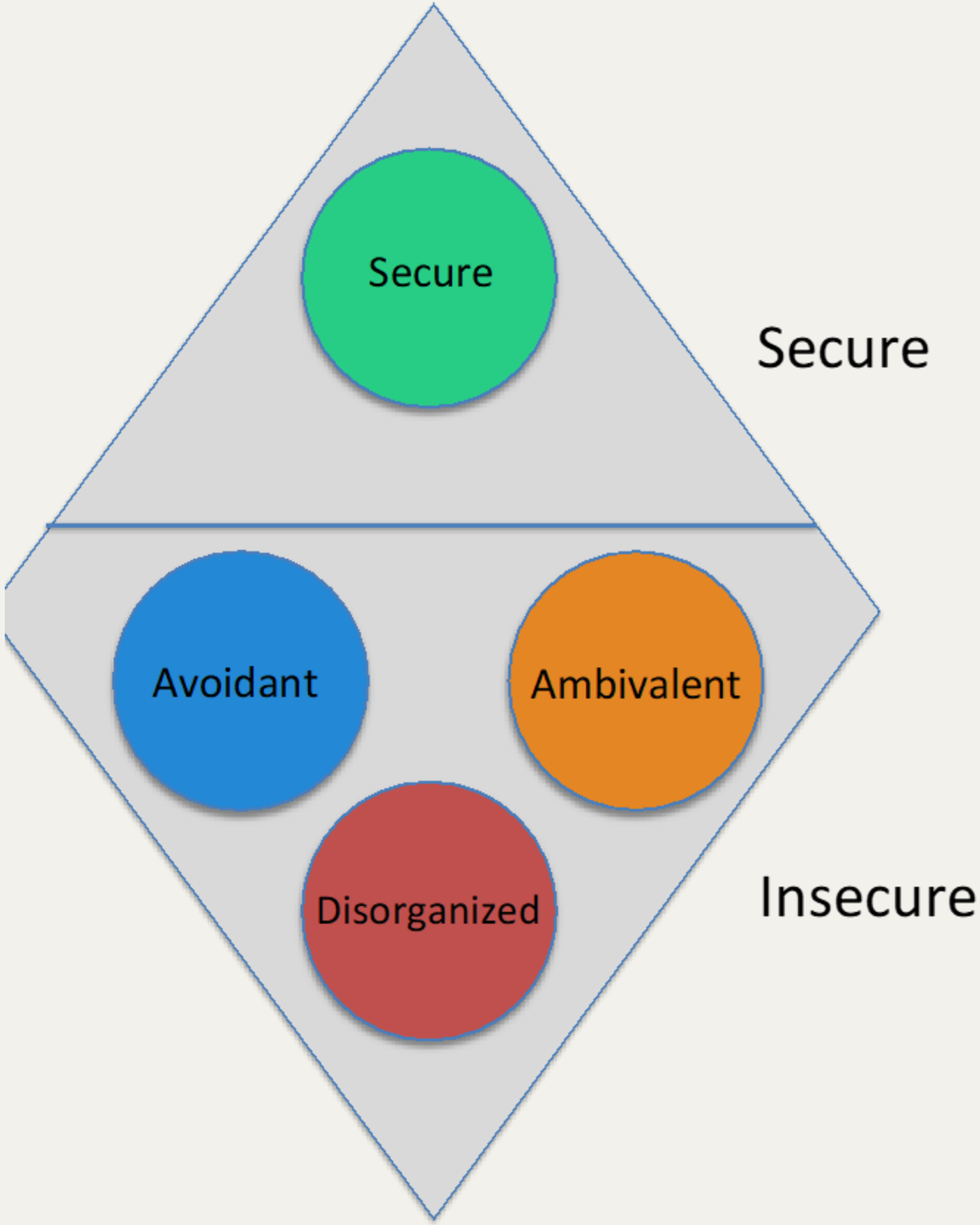

Need Expressed
Distress
Sympathetic Nervous System
Excitatory Neurotransmitters
Needs not met -
Chronic distress
Need Met
2-3 yrs.
Behavioral Dysregulation
4-6 yrs.
ADD/HD Symptoms
8-10 yrs.
Depression/ Anxiety (Agitated Dep./Agg.)
12+ yrs.
Bipolar Disorder (Beh./Emot. Disintegration)
Trajectory of Mental Illness

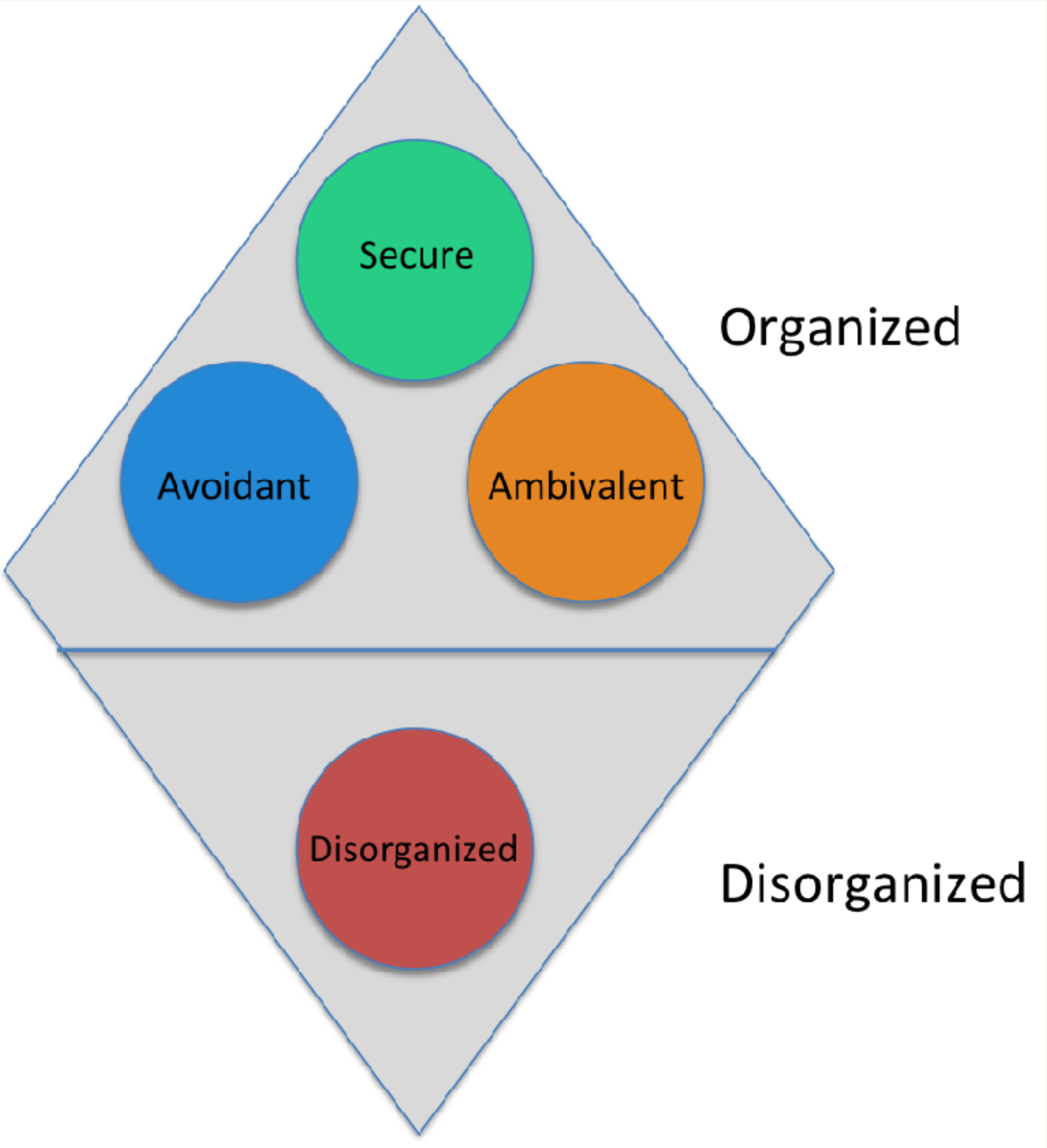
TBRI

Attachment Styles

Secure versus Insecure

BRI illustration





Organized versus Disorganized

TBRI Illustration

Disorganized Attachment

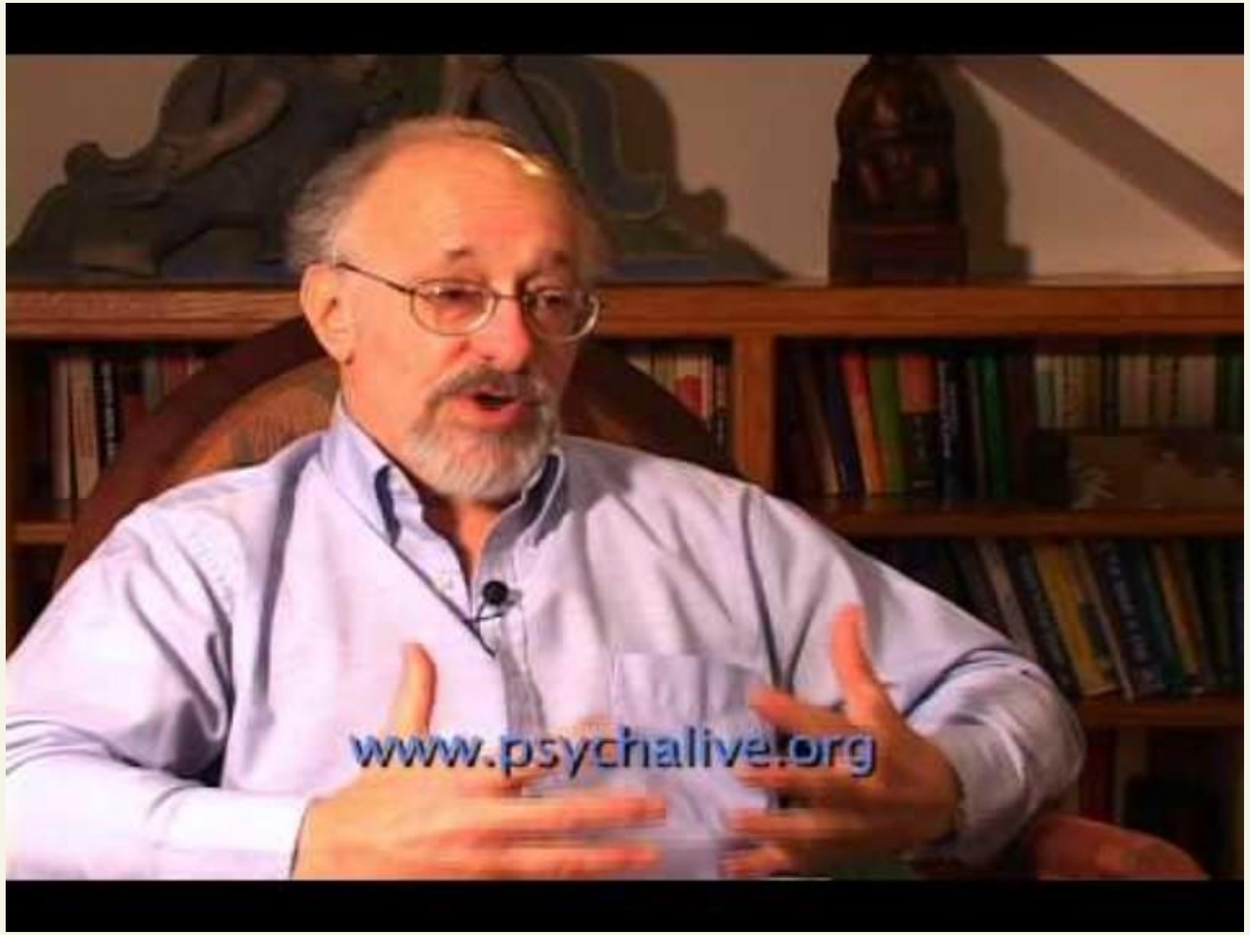
Disorganized Attachment is an insecure attachment style characterized by inconsistent and unpredictable behavior, often stemming from a history of trauma or inconsistent parenting.

Pervasive disorganization (chaos), inconsistent use of attachment-related strategies, attempts to control the caregiver (solicitous, coercive), episodic breakdowns within an organized strategy.

TBRI

Five B’s of Relational Trauma

- Brain
- Biology
- Body
- Behavior
- Beliefs


www.psychalive.org

Memories

Implicit Memory

The unconscious retention and use of information that cannot be consciously recalled or retrieved.It encompasses memories that influence our behaviors and actions without our awareness.

Explicit Memory

The conscious and intentional retrieval of information. It encompasses memories of specific events, facts, and personal experiences that can be consciously recalled and described.

Disrupted Attachment

Disorganized Attachment

Relational Trauma

Complex Trauma

What are some of the challenging behaviors you encounter as a caregiver?

Behaviors

ANGER

SUBSTANCE USE

SOMATIC COMPLAINTS

MELTDOWNS

SEXUALIZED BEHAVIORS

BATHROOM ISSUES

RUN AWAY

SPACEY

CLINGY

LASHING OUT

TANTRUMS

LYING

FEARFUL

SELF-HARM

SILLINESS

WORRY

SADNESS

DESTROYS PROPERTY

DEFIANT

HYGIINE ISSUES

VIOLENT PLAY

HPERACTIVITY

EMOTIONAL LABILITY

OPPOSITIONAL

NIGHTMARES

SOCIAL ISSUES

PROCASTINATE

AGGRESSION

BABY TALK

HOARDING

YELLING

CONTROLLING

AGGRESSION

MISTRUSTFUL

IMPULSIVE

SUICIDALITY

TROUBLE CONCENTRATING

DEVELOPMENTALLLY YOUNGER

WHY DO WE DIAGNOSE?

WHEN DO BEHAVIORS GO FROM JUST BEHAVIORS TO NEEDING PROFESSIONAL HELP?

Functional impairments refer to difficulties or limitations in an individual's ability to perform daily activities and participate in various aspects of life due to mental health conditions. These impairments can affect different domains of functioning, including: Social, Academic/occupational, Emotional, Cognitive functioning, and Daily Living activities,

Purpose of Diagnosis

- Understanding root cause
- Guides intervention & treatment
- Provide needed supports
- Shared language to describe behaviors
- Reduce stigma and increase empathy
- GET HELP!

Reactive Attachment Disorder is characterized by a pattern of inhibited, emotionally withdrawn behavior toward adult caregivers. The DSM-5-TR diagnostic criteria for RAD are as follows:

A. A **consistent** pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, as evidenced by both of the following:

1.The child **rarely or minimally** seeks comfort when distressed.
2.The child **rarely or minimally** responds to comfort when distressed.
3. Episodes of **unexplained** irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.

B. **Persistent** social and emotional disturbance characterized by at least two of the following:

1. Minimal social and emotional responsiveness to others.
2. Limited positive affect.

C. **The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:**

1. Social neglect or deprivation (e.g., persistent lack of having basic emotional needs met by caregiving adults).
2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A.
E. The criteria are not met for autism spectrum disorder.
F. The disturbance is evident before age 5 years old.
G. The child has a developmental age of at least 9 months.

Additional Info in DSM:

- According to DSM the disorder is seen relatively **rarely** in clinical setting.
- These kids show no selective attachments.
- No consistent effort for comfort, support, nurturance, or protection from caregivers.
- Minimal reaction to comfort.
- Absence of expression of positive emotions.
- Emotional regulation is compromised.

LIMITS OF RAD DIAGNOSIS

- PATHOLOGIZES SURVIVAL RESPONSE OF AN INFANT/CHILD
- ATTACHMENT IS RELATIONAL, RAD IS A DIAGNOSIS OF AN INDIVIDUAL NOT A RELATIONSHIP
- STUDIES HAVE SHOWN THAT IT IS OVER DIAGNOSED IN COMMUNITY SETTINGS
- CHALLENGING BECAUSE IT OVERLAPS WITH MANY OTHER DIAGNOSISES.
- DIAGNOSIS RELIES ON A VERY THOROUGH ASSESSMENT ON CHILD'S HISTORY, SYMPTOMS, AND ATTACHMENT BEHAVIORS
- CRITERIA INCLUDES NEEDING EVIDENCE OF "EXTREMES OF INSUFFICIENT CARE."
- DIAGNOSING RAD TAKES SPECIALIZATION TO DIAGNOSIS
- AGE LIMITATIONS
- ONLY ACCOUNTS FOR ATTACHMENT BEHAVIORS
- CAN FEEL HOPELESS

Disinhibited Social Engagement Disorder

Inapporpriate social boundaries

Lack of caution

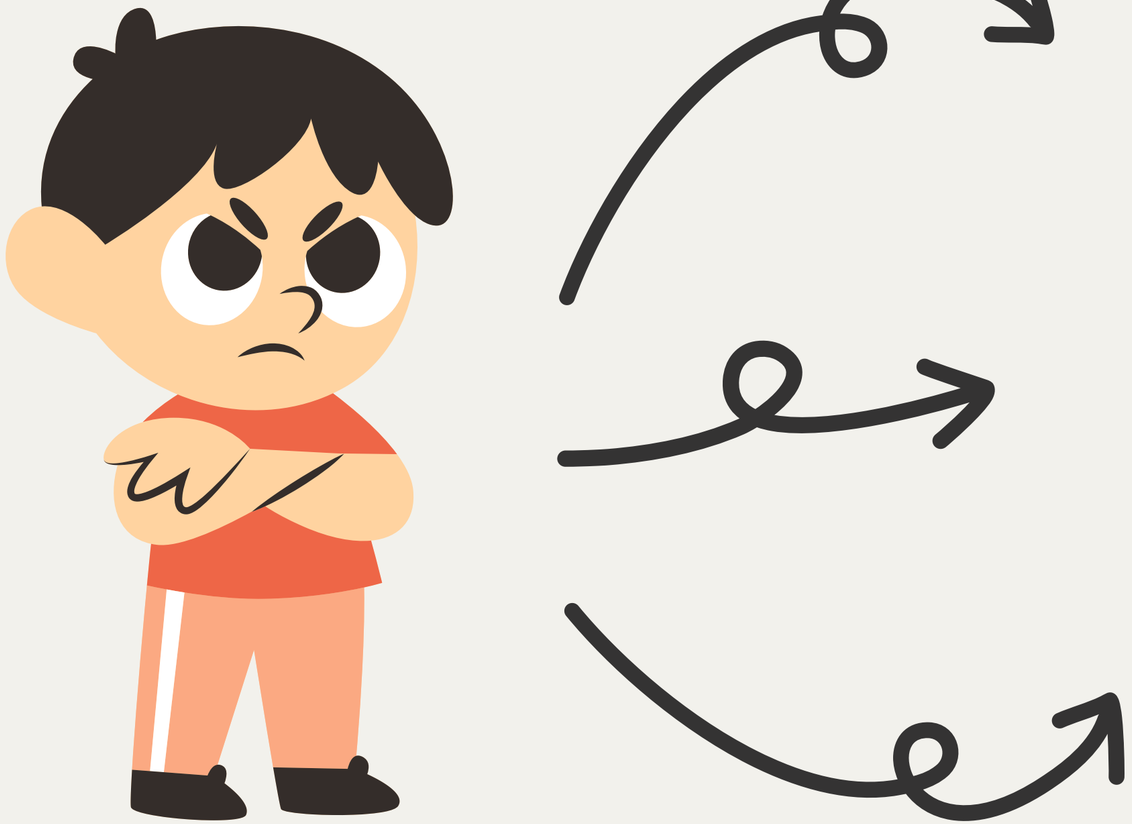
Indiscriminate behaviors

Overly friendly behavior

Lack of stranger anxiety

Poor social boundaries

OPPOSITIONAL DEFIANT DISORER



ANGRY/IRRITABLE MOOD

ARGUMENTATIVE/DEFIANT

VINDICTIVENESS

INTERMITTENT EXPLOSIVE DISORDER

IRRITABLE OR ANGRY MOOD MOST OF THE DAY, ALMOST EVERY DAY

SEVERE TEMPER TANTRUMS OUT OF PROPORTION

ISSUES W/DAILY FUNCTIONING DUE TO IRRITABILITY IN MORE THAN ONE AREA

DISTRUPTIVE MOOD DYSREGULATION DISORDER

- SEVERE RECURRENT TEMPER OUTBURSTS
- VERBAL & OR BEHAVIORALLY
- INCONSISTENT WITH DEVELOPMENTAL LEVEL
- OCCUR 3 OR MORE TIMES PER WEEK
- MOOD BTW IS ANGRY OR IRRITABLE
- MORE THAN 12 MONTHS & 2 OR MORE SETTINGS
- NOT BEFORE 6 YRS OLD OR AFTER 18 YRS
- SYMPTOMS MUST BE SEEN BEFORE 10 YRS OLD

Unable to experience positive Emotions

Negative thoughts about self and other

PTSD

Nightmares

Flashbacks

Avoidance

Forgetting

PTSD IN CHILDHOOD

(DIRECTLY EXPERIENCING, WITNESSING, OR LEARNING THAT IT HAPPENED TO CAREGIVER)

- 6 YEARS OR YOUNGER
- EXPOSURE OT ACTUAL OR THREATENED DEATH, OR SERIOUS HARM
- PRESENCE OF ONE OF FOLLOWING:

1. INTRUSIVE DISTRESSING MEMORIES OF EVENT
2. DISTRESSING DREAMS THAT ARE RELATED TO TRAUMATIC EVENT
3. FLASHBACKS (CAN RE-ENACT IN PLAY)
4. DISTRESS RELATED TO CUES THAT SYMBOLIZE OR RESEMBLE EVENT
5. REACTIONS TO REMINDERS OF EVENTS

TANTRUMS

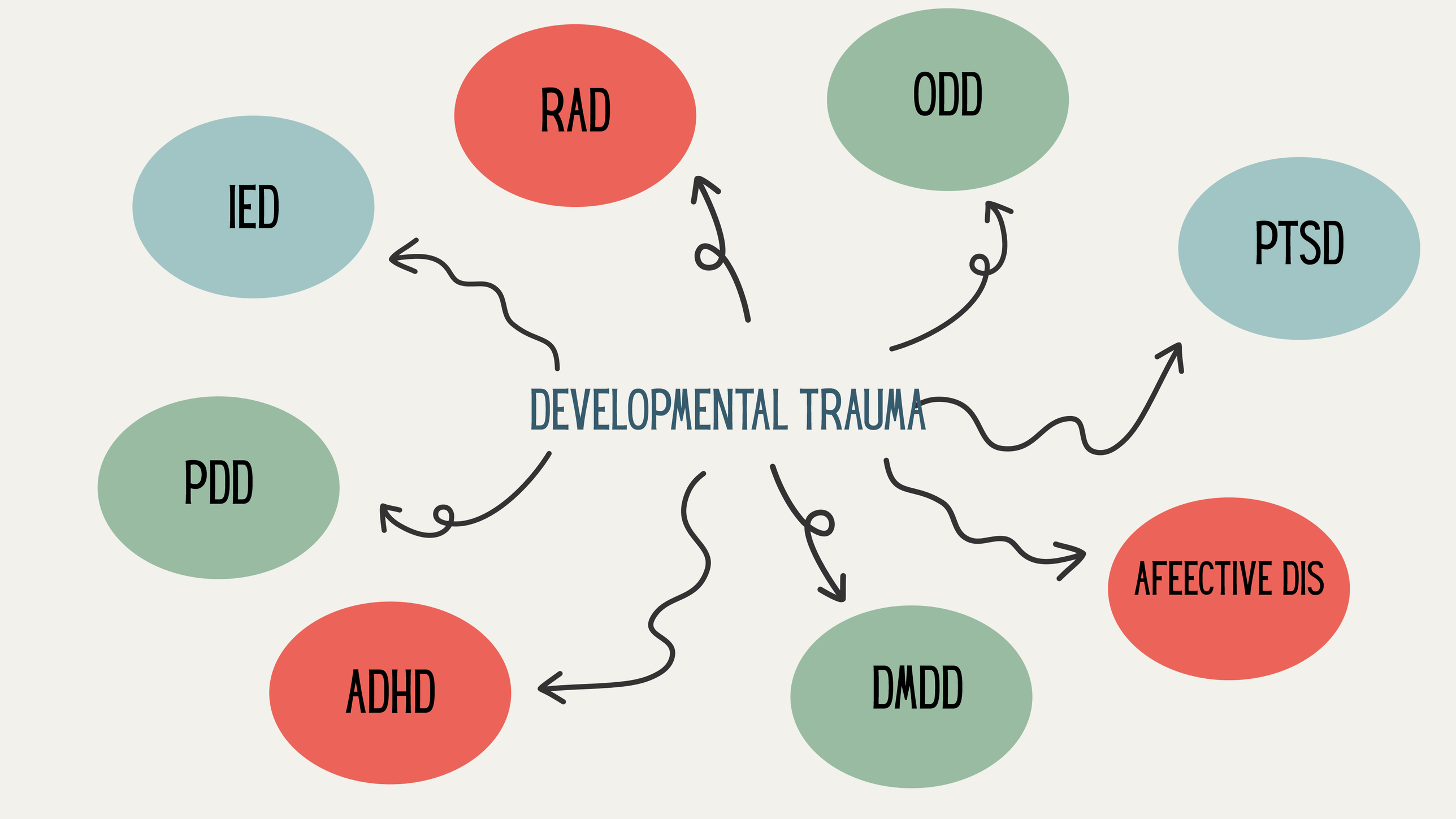
ARGUES

TROUBLE FOLLOWING DIRECTIONS

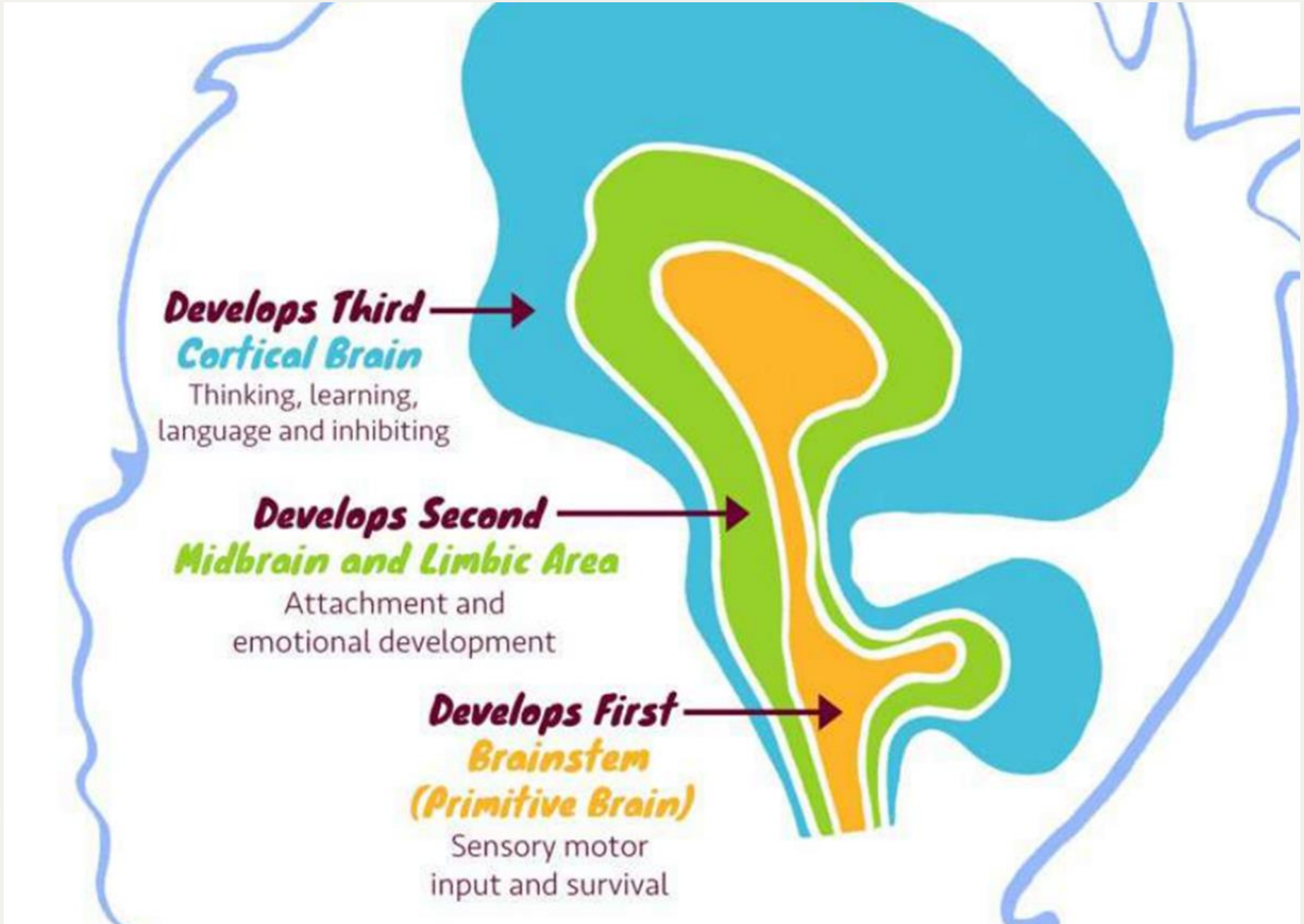
PICKY EATER

HYPER ACTIVE

FINDING THE BEST FIT

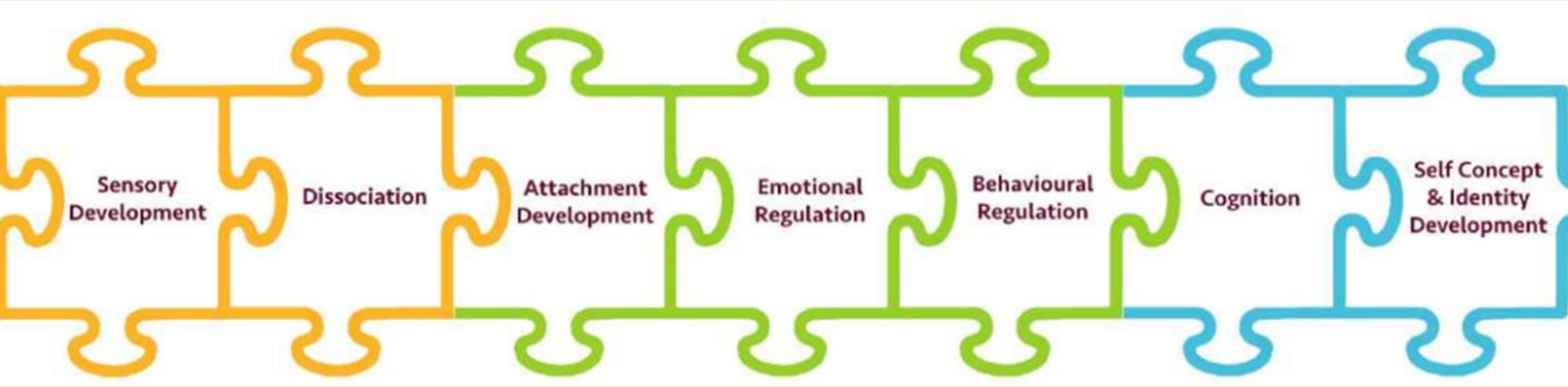

RAD
ODD
IED
PTSD
DEVELOPMENTAL TRAUMA
PDD
AFEECTIVE DIS
ADHD
DMDD

DEVELOPMENTAL TRAUMA IS THE TERM USED TO DESCRIBE THE IMPACT OF EARLY, REPEATED TRAUMA AND LOSS WHICH HAPPENS WITHIN THE CHILD'S IMPORTANT RELATIONSHIPS, AND USUALLY EARLY IN LIFE



BEACON HOUSE

7 Pieces of Developmental Puzzle



BEACON HOUSE

Signs of:

Sensory Problems at Home

- Strong dislike for certain foods & textures
- Strong dislike for touching or overly tactile Sucking, biting, chewing to self-sooth
- Difficulty knowing when they are hot/cold; hungry/full or when they need the toilet

Sensory Problems at School

- Difficulty with concentration & attention
- Overwhelmed by noisy busy classrooms
- Poor handwriting and pencil grip
- Shutting down/zoning out frequently throughout the day

Attachment Problems at Home

- Avoidance of emotional intimacy or emotionally over-spilling
- The parent/carer feels exhausted with the unrelenting demands, crises and emotional needs of the child.
- Boundary setting can trigger a big reaction or noncompliance in child

Attachment Problems at School

- Difficulties processing new information
- Difficulties planning, organizing and completing tasks
- Struggles with transitions, loss and change
- Difficulties in friendships
-

Emotional Dysregulation at Home

- Very limited empathy for others
- Bedtime routine is prolonged and painful
- In teens self harming, drug use, promiscuity

Emotional Dysregulation at School

- Outbursts of anger or distress at small events such as a change in activity
- Immaturity in friendships – jealousy, possessiveness, struggles to share
- Aggression, running off and hiding

Behavioral Dysregulation at Home

- Lying, stealing, hoarding
- Over-eating or under-eating
- Unresponsive to day to day requests (often seen as non-compliance)

Behavioral Dysregulation at School

- Disruptive in class
- Restless, fidgety, moves about the classroom lots
- Slowed down, unresponsive

Dissociation at Home

- The child appears as if s/he is not listening to requests from the parent
- Rapid regressions in age-level behaviour, e.g. suddenly acting like a baby.
-
- Relationships are so changeable it is hard to keep up for the adults

Dissociation at School

- Frequent ‘day dreaming’ & lack of focus; leading to under achievement
- The child is forgetful or confused about things s/he should know, such as friends’ names
- Confusion about day and time

Poor Cognition at Home

- Unable to learn from mistakes
- Forget complicated instructions
- Black and white thinking

Poor Cognition at School

- Difficulties problem-solving
- Struggles to complete a task
-
- Cannot put into words what they are thinking

Poor Self Concept at Home

- Not feeling worthy of accepting love and nurture
- Becoming jealous when their parent/carer pays others attention
- Saying “I’m stupid” or “everyone hates me”

Poor Concept at School

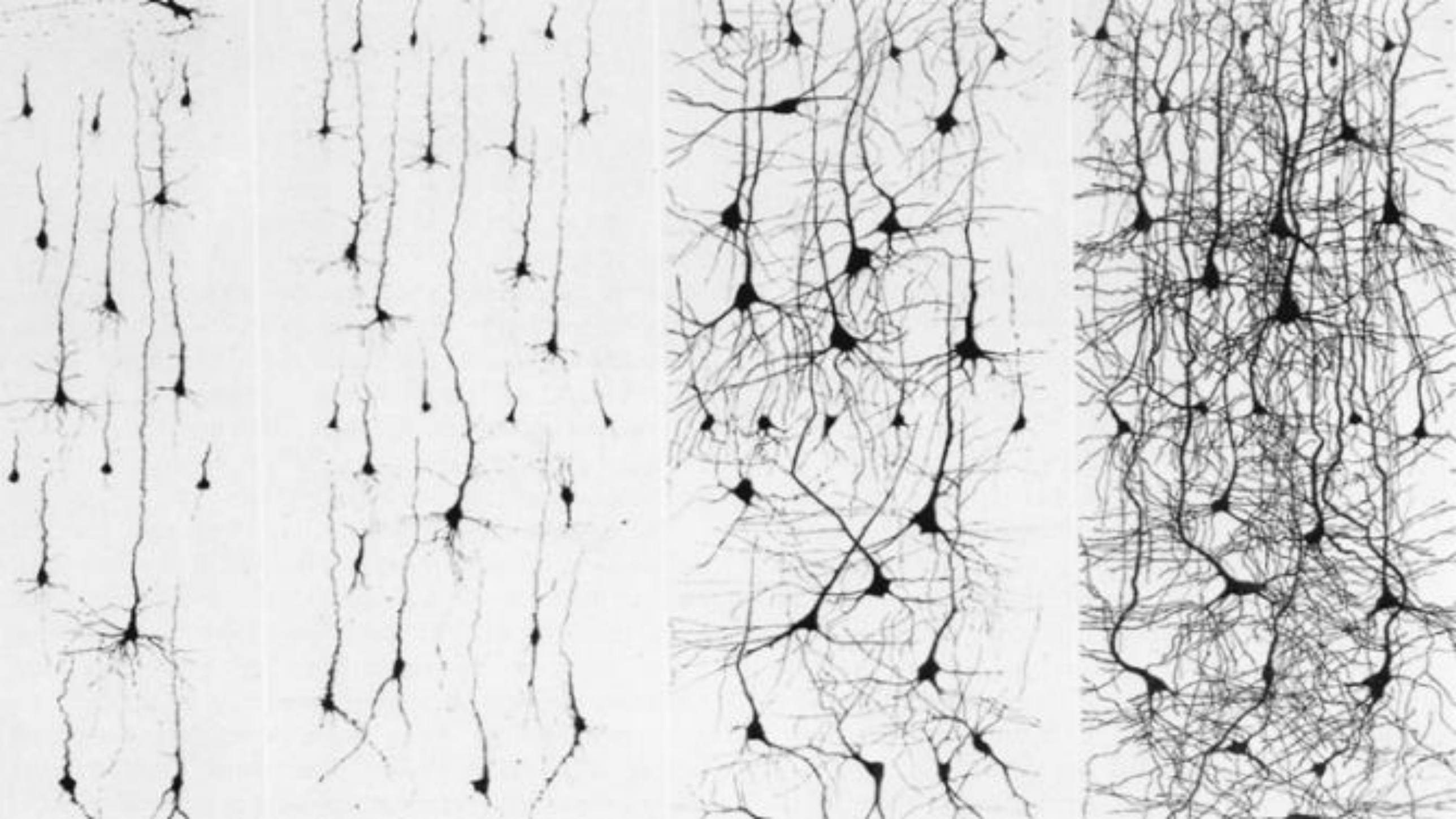
- Being knocked back easily
- Becoming upset at failure
- Self doubt and self criticism
- Not trying for fear of failure

NOW WHAT?

Neuroplasticity:

“It refers to the physiological changes in the brain that happen as the result of our interactions with our environment. From the time the brain begins to develop in utero until the day we die, the connections among the cells in our brains reorganize in response to our changing needs. This dynamic process allows us to learn from and adapt to different experiences”

Celeste Campbel



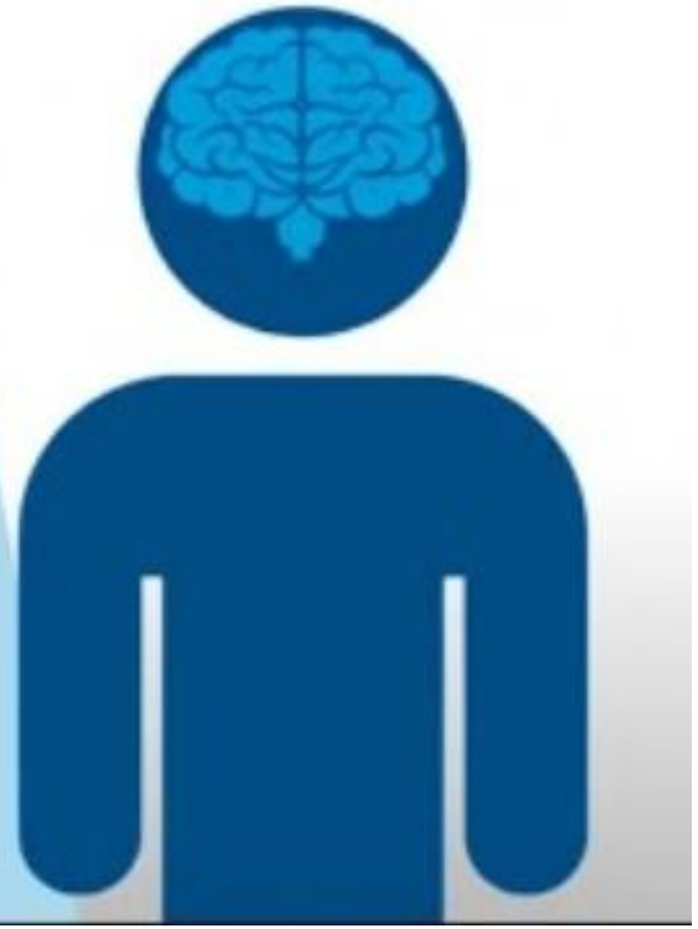
Principles of Neuroplasticity

- Use it or lose it. Learning it once doesn’t mean you know it or can access under stress.
- Use it and improve it. Practice makes perfect.
- Specificity. Focus in on exactly what you want them to learn.
- Repetition. This will start to feel life second nature.
- Intensity matters. Practice with 100% effort.
- Timing matters. Begin as soon as you can.
- Age matters. Young brains are more sensitive and response.

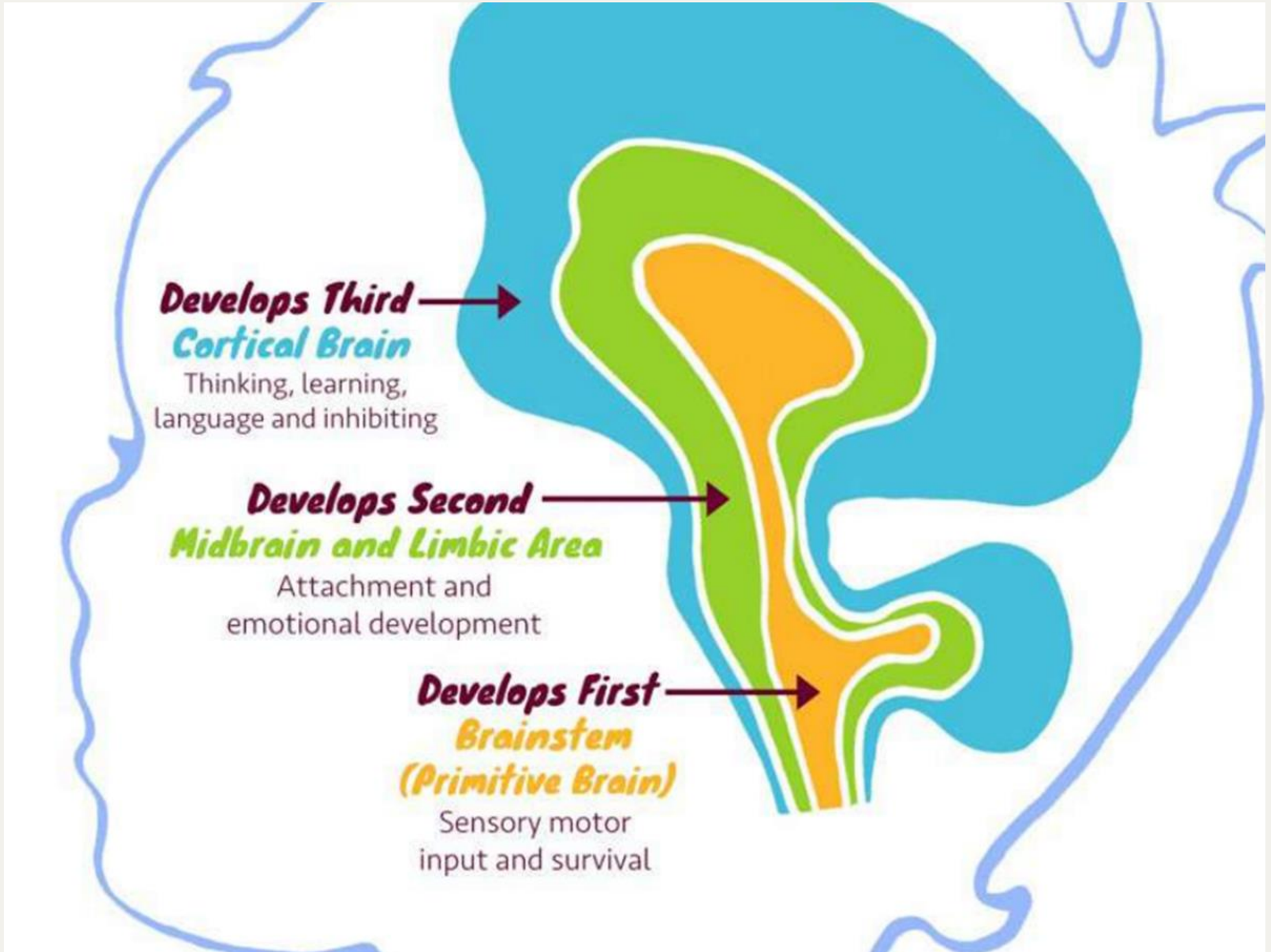
Your paragraph text

sentis positive safety

HOW NEUROPLASTICITY WORKS



Bottom up/Back to Front



BEACON HOUSE

TBRI

Trust Based Relational Intervention

Connecting:

Sharing Power

Giving Choices

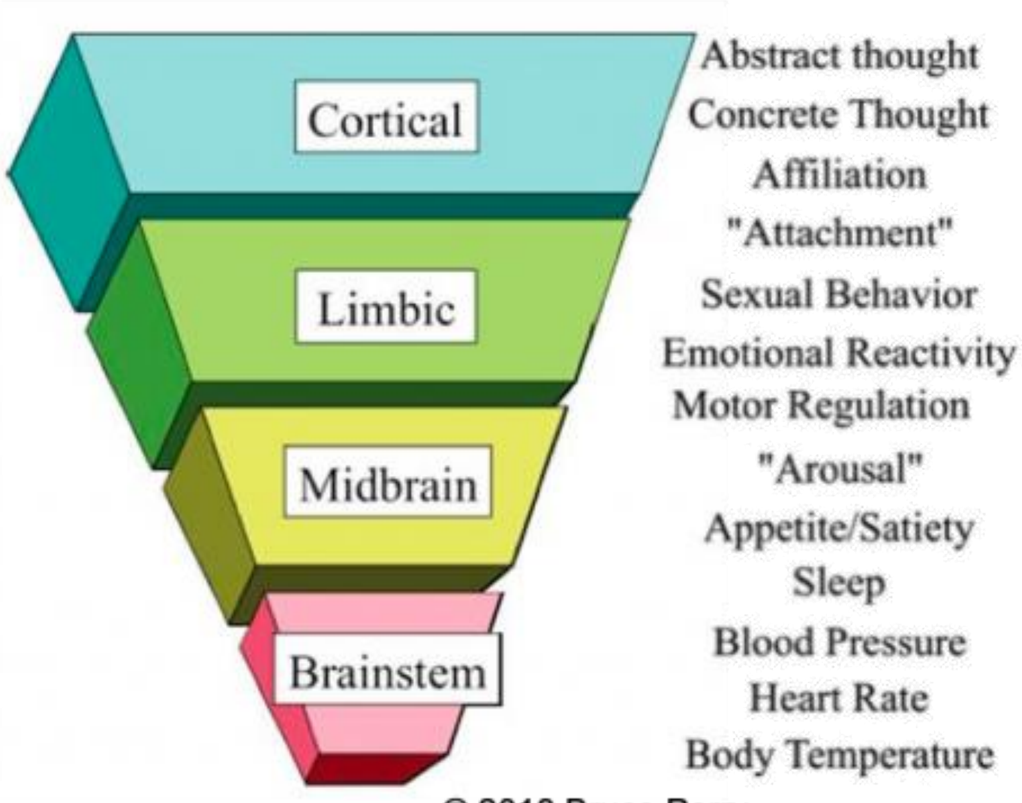
Compromises

Eye Contact

Touch

Play

Neurofeedback Therapy Sequencing



Psychological change

- Develop self-identity
- Improve cognitive function
- Reduce emotional reactivity
- Clear trauma from limbic brain

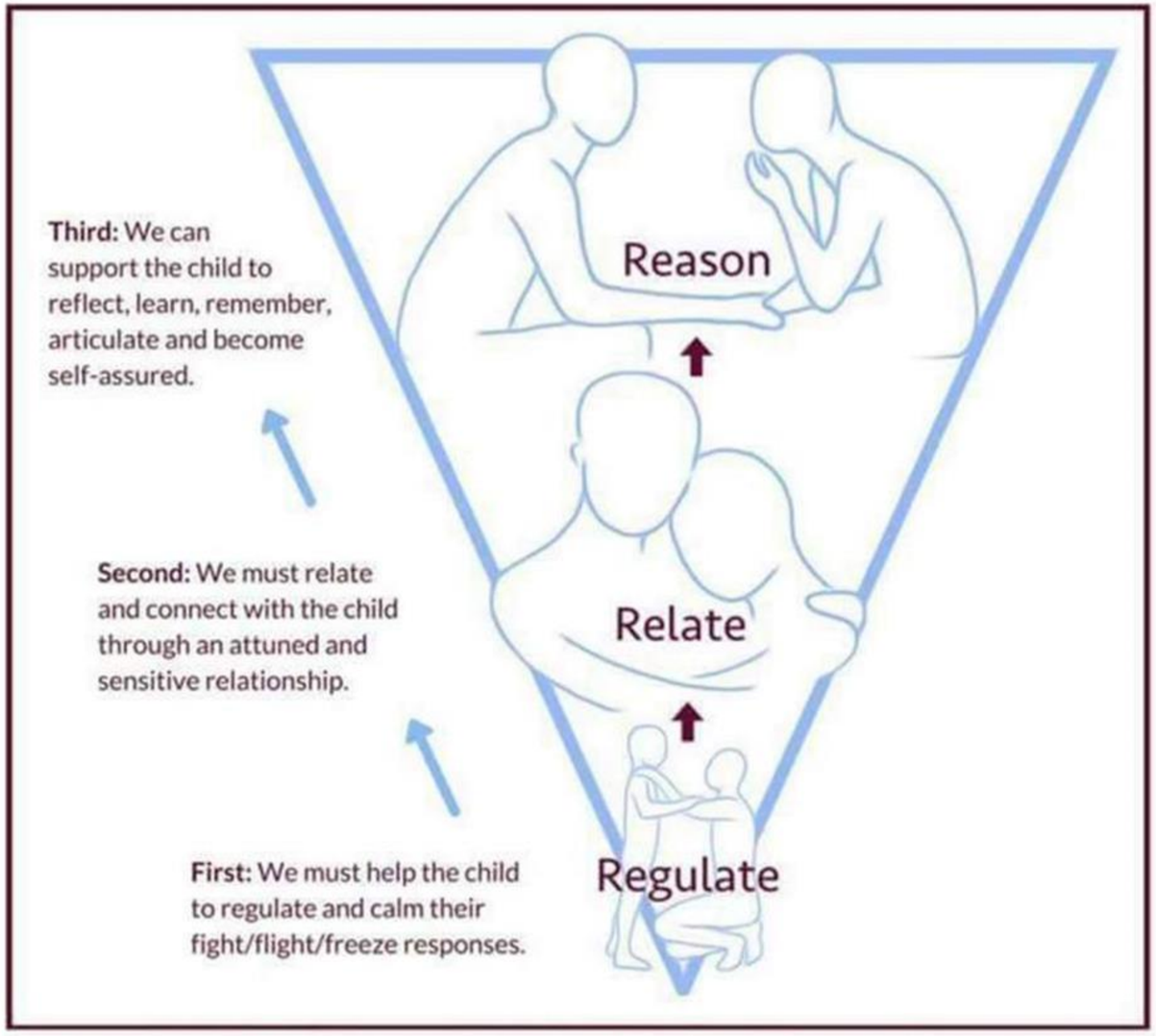
Physiological change

Regulate nervous system arousal:

- Reduce fight/flight/freeze responses
- Improve sleep

The Three R's: Reaching The Learning Brain

Dr Bruce Perry, a pioneering neuroscientist in the field of trauma, has shown us that to help a vulnerable child to learn, think and reflect, we need to intervene in a simple sequence.



Heading straight for the 'reasoning' part of the brain with an expectation of learning, will not work so well if the child is dysregulated and disconnected from others.


Sensory Development
Dissociation
Attachment Development
Emotional Regulation
Behavioural Regulation
Cognition
Self Concept & Identity Development

What do kid’s need from us?

- Give Care, Receive Care, and Ask for Help.
- Caregiver that can stay present and regulated.
- Caregivers who can see that it’s the child’s internal disorganization that is causing difficult behavior. It’s actually very simple but extremely challenging. (Robyn Gobbel).
- Rupture and Repair.

Trauma happens in the context of relationship and is healed in relationship.

THANK YOU FOR ALL YOU DO!!

Resources:

Beacon House- Information on Developmental Trauma and interventions.
https://www.beaconhousedc.org/

Robyn Gobbel- Information, books, podcasts on kids with “baffling behaviors”
https://robyngobbel.com

Bruce Perry- Neurosequential Model of Caregiving
https://www.bdperry.com/_files/ugd/5cebf2_93fea3b2390b416aa73570db72e67a73.pdf

Trust Based Relational Intervention- Great resources for adoptive/foster caregivers. They also have many YouTube videos.
https://child.tcu.edu/about-us/tbri/#sthash.MMwAXEaI.dpbs

Eli Harwood- ***Raising Securely Attached Kids: Using Connection-Focused Parenting to Create Confidence, Empathy, and Resilience***

Karen Purvis- Connected Parent: Real Life Strategies for Building Trust and Attachment