Building Nursing Relationships with Individuals with Reactive Attachment Disorder of Childhood

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Building Nursing Relationships with Individuals with
Reactive Attachment Disorder of Childhood

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Dedication Page

I would like to dedicate this thesis to all psychiatric nurses, for the difficult work they do and the strength it takes to do it.

Also, to my parents, Mary Sebek and Joseph Phillips for their support and lifelong investment in my learning and success.

Finally, a special thanks to Dr. Joni Walton for the countless hours of advising on this thesis.
Abstract

In the United States alone, 800,000 children within the child welfare system will be diagnosed each year with severe attachment disorder because of serious abuse and neglect. Most available treatment or methods of therapy involve psychiatric nurses working to build trust and the formation of healthy attachments and relationships with children with Reactive Attachment Disorder of Childhood (RAD). The purpose of this thesis was to explore relationship building between the psychiatric nurse and the child with RAD from the perspective of the nurse. Participants were four psychiatric nurses currently working in the field who had at least two years of adolescent psychiatric treatment experience. The participants were all asked about their experience forming relationships with children diagnosed with Reactive Attachment Disorder. Field notes and theoretical memos were written throughout the study. A theoretical model was developed to describe the basic social processes. Classic grounded theory analysis was used to analyze the data and discover categories. Transcripts were read, coded, and categories emerged. The core category identified from this study was “Developing a Relationship.” The supporting categories were “Recognizing Personal Weaknesses,” the nurses ability to objectively work with a patient while taking care of themselves, “Knowing their Behaviors,” recognizing the characteristics and expected behaviors of children with RAD, and finally “Initiating therapy,” when the relationship is formed successfully. A theoretical model was developed which describes the cycle of the therapeutic nursing relationship. This model can be used by nurses to gain an understanding of the phases of the therapeutic relationship between the nurse and patient, and can be modified to fit clinical practice.
CHAPTER I

Background

In the U.S alone, 800,000 children within the child welfare system will be diagnosed every year with severe attachment disorder because of serious abuse and neglect (The International Child and Youth Care Network, 2010). Reactive attachment disorder of childhood is an attachment disorder attributed to the maltreatment or trauma of young children. The physical findings and general medical condition related to Reactive Attachment Disorder of Childhood (RAD) indicate the effects of general neglect (American Psychiatric Association, 2000). The phase of attachment for human beings begins at birth, with the attachment of infant and caregivers. Failure of this attachment to occur leads to severe disturbances in the emotional growth of children. The Diagnostic and Statistical Manual Fourth Edition with Text Revision (DSM-IV-TR) defines Reactive Attachment Disorder (RAD) as “a markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age five and is associated with grossly pathologic care” (American Psychiatric Association Diagnostic and Statistical Manual, 2000, p.127). Grossly pathologic care in this case refers to “persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection; persistent disregard of the child’s basic physical needs; or repeated changes of primary caregiver that prevent formation of stable attachment” (American Psychiatric Association, 2000, p. 128). Under the DSM-IV-TR diagnosis of RAD, there are two subtypes: inhibited and disinhibited. The inhibited subtype refers to those children unable to initiate and accurately participate in social interaction acceptable to their developmental status, while the disinhibited subtype refers to those with no discrimination or selectiveness in their
attachments to others (American Psychiatric Association, 2000). The typical subtype manifestations include indiscriminate affection with disinhibited RAD and indifference to human interaction with inhibited RAD.

**Normal Attachment**

Secure attachment development with a caregiver is a vital aspect of general and mental health. Bowlby (1988) studied the idea of attachment formation between children and their caregivers. Bowlby stated “For those who succeed the rewards are great; but for those who have children but fail to rear them to be healthy, happy, and self-reliant the penalties in anxiety, frustration, friction, and perhaps shame or guilt may be severe” (Bowlby 1988, p.1). Bowlby explained that without this secure attachment, children are not able to live their lives without inner turmoil. In agreement with Bowlby’s ideas, Zilberstein emphasized the importance of a secure attachment in learning and growth and stated, “Secure attachments provide a “secure base” with the caregiver that fosters safe exploration and learning” (Zilberstein 2006, p. 55). Without a secure attachment, the child’s development in these areas may be delayed or absent. Both Bowlby and Zilberstein expressed the idea that a secure attachment with a caregiver is vital for a child’s normal growth and development.

Hughes (2003), an expert in attachment, has studied children with RAD for many years. Hughes provided unique case studies and theories about the effects of malformed attachment on children’s growth and development. Hughes attested to the importance of a functional attachment between caregiver and child. He stated “in healthy families, a baby forms a secure attachment with her parents as naturally as she breathes, eats, smiles and cries. This [attachment] occurs easily, because of her parents’ attuned interactions with
her” (Hughes, p. xi). Without this “attuned interaction” between the infant and the parents, an attachment does not form easily. Much of normal attachment is attributed to the abilities of the parent or caregiver and not to the child. Unfortunately, Hughes has studied many cases where the child endures lasting damage because of this lack of “attuned interaction” (Hughes, p. xi).

**Abnormal Attachment**

There are several different types of atypical attachments. These abnormal forms vary between secure, insecure, and disorganized. Bowlby (1988) pointed the finger at parents for unsuccessful relationships and continuing and permanent damage. In the event that a secure attachment is broken, Bowlby derived three stages of grief related to the child’s mourning and separation. The three stages are protest, despair, and detachment. Reactive Attachment Disorder of Childhood relates most closely with those children who have disorganized attachment. They fit this subgroup because “attachments vary in their quality in accordance with the type of attachment relationships a child has experienced” (Zilberstein, 2006, p. 55). As previously stated, RAD can be attributed most readily to abuse and neglect. This type of traumatic attachment experience holds the highest correlation with disorganized attachment. RAD presents with a wide range of signs and symptoms and is a serious clinical condition. The typical clinical traits of RAD are defined by the child’s behavior and social interactions. According to the American Academy of Child and Adolescent Psychiatry (2009), one or more of the following concerns is associated with the development of RAD:

- severe colic and/or feeding difficulties
- failure to gain weight
- detached and unresponsive behavior
- difficulty being comforted
- preoccupied and/or defiant behavior
- inhibition or hesitancy in social interactions
- disinhibition or inappropriate familiarity or closeness with strangers. (p. 1)
Due to a lack of secure initial attachment, children with RAD are at risk for impaired attachment throughout their life. Disorganized children display an array of traits effecting their social and physical behaviors and result in increased risk for “later behavioral and emotional difficulties” (Zilberstein, 2006, p.55). Observation and assessment of these characteristics through the use of several behavior scales (to be discussed later) is the first step to diagnosis of RAD.

Hughes (1997) addressed the issues which arise in treating and following children who have attachment insecurities and their treatment progression. Hughes has published many works including books and articles on attachment disorders and case studies on individual’s attachment problems over the last decade. Hughes is seen to be one of the leaders in research and theory of attachment disorders through his extensive research which gained public interest in 1997. Hughes reported a specific case in 2006 where he identified the client as “Katie” and documented how her history of serious abuse and neglect in her early childhood impacted her future relationships until the age of eight. While after the age of eight, Hughes did not claim her cured, “Katie” had learned how to form a relationship with her foster mother and foster family. Hughes argued that with attachment disorders, a “therapeutic attitude” is the best way to approach the care for the child. In “Katie’s” case the successful interventions were “shame reduction and attunement in reference to inter-subjective affective experiences” (Hughes 2006, p. 279). These interventions come from the Dyadic Developmental Psychotherapy (DDP) approach, which Hughes supported. Hughes stated that the DDP theory and corresponding Attachment-focused Family Therapy (AFFT) are “based on the premise that the development of children and youth is dependent upon and highly influenced by
the nature of the parent-child relationship” (Hughes, 2011, para. 2). The many case studies which Hughes has published give a much needed insight into the behaviors seen in children with RAD and how these abnormalities manifest themselves in the activities of daily life.

**Risk Factors for the Development of RAD**

There are many factors that increase risk for developing RAD and social environment plays a key role in attachment. Some of these risk factors include the following: living in an orphanage, institutional care, frequent changes in foster care or caregivers, inexperienced parents, prolonged hospitalization, extreme poverty, physical, sexual or emotional abuse, forced removal from a neglectful or abusive home, significant family trauma such as death or divorce, and parents who have a mental illness, anger management problems, or drug or alcohol abuse (MFMER, 2009). According to The International Child and Youth Care Network, research supports the idea that up to 80% of high-risk family situations (abuse and neglect, poverty, substance abuse, domestic violence, history of maltreatment in parents’ childhood, depression and other psychological disorders in parents) create severe attachment disorders in their children (ICYCN, 2010). The diagnostic criterion was added to the Diagnostic and Statistical Manual Fourth Edition with Text Revision (DSM-IV-TR). The disorder was reclassified and the two subtypes were identified. Another classification of RAD appears in the International Classification of Diseases Tenth Edition (ICD-10). While both the DSM-IV-TR and ICD-10 descriptions hold similar criteria, the ICD-10 includes more specific examples and the subtypes are classified differently as F94.1 and F94.2. (WHO, 2007). There is an increasing debate on whether the diagnostic tools for RAD provide a
sufficient diagnosis for extreme cases of this disorder or those cases that do not fit the typical presentation by researchers to be named. This is evident in the differences between the ICD-10 and DSM-IV-TR. Immediate results are not seen in treatment of this disorder. However, much of the research pertaining to RAD indicates that this disorder is highly preventable and readily treatable with intensive therapy and assistance in social interaction over time (Hughes 2006).

**Treatment**

Reactive Attachment Disorder (RAD) is a highly preventable but limitedly treatable behavioral illness. There are many different treatment modalities. Holding therapy has been identified as an effective treatment for some children and adolescence with disorganized attachment. Holding therapy is designed to provide a certain amount of time with a caregiver being held and coddled (Grabe, 1990). This is typically done in a long term treatment setting with therapists and staff caregivers. The idea is to cause the child to revert to an infant-like state where a trusting secure attachment can be formed on basic need and touch. Zilberstein (2006) addressed the different opinions of holding therapy and noted that it has been shown to focus more on “aggression and noncompliance” rather than attachment (Zilberstein 2006).

Other therapies include long-term treatment in facilities where staff, nurses, and therapists teach these children how to form proper attachments. The focus of the teaching can vary from how to interact with peers and staff properly while keeping personal boundaries and learning “safe touch” to how to manage the child’s aggression and deal with the effects of abuse emotionally. While there is hope to treat children with RAD, it is a very lengthy process. Improvement in their behavior and social shortcomings may
take years. Some may never fully recover from the effects of their disorganized attachments (Zilberstein 2006).

**Social Relation**

RAD affects the social and emotional wellbeing of the person, as well as his or her family and community. Some children with RAD show indiscriminate affection, which is attributed to the child’s constant search for love, approval, and acceptance in all interactions (ECAPJ, 2006).

The *European Child & Adolescent Psychiatry Journal* (ECAPJ) reported indiscriminate affection as “behavior that was affectionate and friendly toward all adults (including strangers) without the fear or caution characteristic of normal children” (ECAPJ, 2006, para. 3). This behavior is more specific to the disinhibited subtype (American Psychiatric Association). Children who do not display these symptoms of the disorder tend to be more careful with their affections towards others; this trait is attributed to the inhibited subtype. The affected child’s attachment style provides a struggle for the family since children with RAD have difficulty with touch, trust, self-soothing, aggression, and self-concept (MFMER, 2009). This provides problems for the afflicted client and his or her family’s relationship. According to ECAPJ, the overall key feature of RAD is the social disturbance it causes. With the constant search for reassurance and reaffirmation that comes with RAD, it proves extremely difficult for children who suffer from this disorder to form healthy relationships. Not only does this pose a problem for building and maintaining relationships in a family setting, but in a social setting in the community as well (American Psychiatric Association).
RAD is seen very frequently in children in school and state systems such as foster care facilities, group homes, and children’s psychiatric hospitals. Children with RAD manifest serious difficulties interacting with peers in a normal, structured social setting and are often disruptive in school (ICYCN, 2010). Children who have interrupted attachments are at risk for exhibiting emotional, behavioral, social, cognitive, developmental, physical and moral problems (ICYCN, 2010). They are unable to have normal interactions with others because of their lack of security and support provided by a secure attachment at home with a primary caregiver (ICYCN, 2010).

**Research Question**

As nurses working with children who possess the diagnosis of RAD there are many factors that need to be taken into consideration while providing care. It is important to encourage a slow progression towards a trusting relationship between the client and the nurse, and to be extremely cautious about the attachment and personal boundaries of the child with the nurse. The purpose of this thesis was to explore relationship building between the psychiatric nurse and the child with Reactive Attachment Disorder from the perspective of the nurse. The research question for this honors thesis was as follows: How does the psychiatric nurse develop a safe, treatment-centered relationship with a client diagnosed with RAD within the pediatric psychiatric setting?
CHAPTER II

Review of Literature

Reactive attachment disorder (RAD) is an under studied and under diagnosed disorder in the mental health field. According to Boris and Zeannah, the DSM criteria are difficult to use when diagnosing such young children and there has never been a study that followed the progression of attachment and accounted for the characteristics used to diagnose attachment disorders (Boris & Zeannah, 1998). Attachment disorders are often diagnosed along with other behavioral problems because they share symptoms with several behavioral diagnoses. Behavior and attachment problems are most often diagnosed in institutional or school settings but often can be overlooked and classified by uneducated caregivers as some variations of normal childhood behavior or children just “acting out.” Experts define attachment “as a lasting psychological connectedness between human beings” (Bowlby, 1969, p.194). Most research suggested that RAD is caused by ineffective attachment forming behaviors in early childhood between the individual and the caregiver.

Characteristics and Behaviors

Reactive Attachment Disorder is the inability of the child to form a normal and loving relationship with others (Hall & Geher, 2003). Hall and Geher (2003) reported the similarities and differences of children with and without RAD. The experimenters compared the children by creating intricate questionnaires filled out by the children’s parents to acquire their findings using parental self-reporting measurements. Hall and Geher discovered that children with RAD scored lower in empathy and higher in self-monitoring behaviors. Self-monitoring behavior was defined as the behaviors used to modify and regulate ones own behavior, for example, the social appropriateness of the
behavior. This was especially evident in some surveys which suggested “children with RAD may systematically report their personality traits in an overly positive way” (Hall & Geher, 2003). The scores also indicated higher levels of behavioral issues within the experimental group of RAD individuals. Some typical behavioral issues included increased aggression, social inability, and defiance. The study by Hall and Geher aimed to gain a better understanding of RAD through a study of the behaviors, which are present in children with RAD. Identification of specific behavior related to RAD is important for nurses to be able to recognize. This is significant to the clinical practice of nursing and vital to creating a therapeutic relationship with these children.

Children with severe attachment disorders will have more obvious behavioral issues than those who either have no disorder or a milder form of the disorder. Knowing the behaviors of these children may enable better social interaction between the nurse and the individual. Once the specific behaviors are identified, the nurse can help determine the need for treatment and begin building a therapeutic relationship to increase their ability to function more normally in social settings.

**Diagnosis**

RAD is an under diagnosed and under treated disorder. Boris, Zeannah, Larrieu, Scheeringa, and Heller’s (1998) study was designed to address the criteria for diagnosing attachment disorders in children. The first item addressed by the article was a review of data and information, second was validity of the characteristics for diagnosis, and third was analysis of variables in relation to the occurrence of attachment disorders. This study was the first to evaluate reliability of characteristics present during diagnosis of attachment disorders in young children (Boris et al., 1998). The study involved a clinical
survey of 48 cases of RAD through a psychiatry clinic. The experimenters looked at several instruments that provided the criteria proposed to diagnose RAD. These instruments included the DSM-III, DSM-IV, ICD-10, and the Parent-Infant Relationship Global Assessment of the relationship. Additionally, the researcher’s “primary purpose of this study was to compare the reliability of differing sets of criteria for attachment disorders by using a retrospective case review” (Boris et al., 1998, p. 295). The study critiqued the criteria used to evaluate the function of relationships. Each diagnostic tool focused on different behaviors noted and had different criteria. Boris concluded that none of the diagnostic tools appeared to be more proficient in their diagnosis than the others.

The study Boris et al. (1998) performed on diagnostic techniques used a table with the description of types of attachment disorders. The study showed that the “reliability of alternative criteria was acceptable, but the reliability of DSM-IV criteria in diagnosing attachment disorders was marginal” (Boris et al., 1998, p. 296). This indicated that there was not a large difference seen in the accuracy of the diagnosis of RAD by alternative criteria versus the DSM-IV diagnostic tool. Boris concluded that disturbed relationships are “seen more in infants diagnosed with attachment disorders” (Boris et al., 1998, p. 297) than those without them. Results concluded that “attachment disorders may be reliably diagnosed without clear evidence of ‘pathogenic’ parental care, and this requirement should be removed from the DSM revision” (Boris et al. 1998, p. 297). Pathogenic care refers to emotional neglect or repeated changes of caregivers. When diagnosing RAD, psychiatrists look at an array of diagnostic scales and characteristic criteria.

Diagnosis of RAD has increased greatly in recent years as a way to describe a
variety of behavioral issues in children. Although use of this diagnostic criteria has increased, there has not been sufficient data collected on RAD because of its constant criteria changes and the therapists’ and researchers’ unfamiliarity with the appearance of the symptoms in the clinical setting. Gordon, Brown, and Shumate’s (2005) study on the Correlates of the Randolph Attachment Disorder Questionnaire (RADQ) in a Sample of Children in Foster Placement critiqued the use of the RADQ as a diagnostic method for Reactive Attachment Disorder (RAD). Attachment expert Randolph stated that attachment problems have an underlying emotional and behavioral predisposition (Gordon et al., 2005). The study examined the mental and attachment issues relevant with this group of youth using the Child Behavior Checklist (CBCL) and the Randolph Attachment Disorder Questionnaire (RADQ). The RADQ uses 30 items answered with a 5-point Linkert-scale format. The study included ninety-eight children who were placed with “biological parents, foster parents, adoptive parents, group homes, therapeutic foster homes, and mental health therapeutic group homes” (Gordon et al., 2005, p. 74). The age ranged from ages 5-18. The results of the study indicated that children living in long term foster care have the same symptoms as children not living in foster care (Gordon et al. 2005). The conclusion suggested that RADQ is subjective and lacks specificity because it is not used for diagnosis as often as the general DSM-IV criteria (Gordon et al., 2005, p. 71). The data also “showed that virtually all the RADQ scores were correlated with the CBCL scores” (Gordon et al. 2005, p. 84). The RADQ has not yet been validated fully, as such; use of the scale to diagnose RAD individuals is debatable. The authors claimed that further research needed to be carried out with more samples and participants in different areas. The findings of the study suggested reassessment of the DSM criteria for diagnosis
Attachment disorders are characterized by many different behaviors exhibited by an individual. Becker-Weidman (2009) identified a discrepancy in chronological and developmental ages in children with RAD. The study measured the performance of the children on the Vineland Adaptive Behavior Scales-II. The study explored the effect trauma had on children’s scores on the Vineland Adaptive Behavior Scales-II. The information analyzed was collected from the Center for Family Development’s data center. The study contained detailed descriptions of the individual participants and what the overall criteria was to be considered to be a part of the study. The data was taken during social interactions of children who were living in a foster care setting or had been placed with adoptive families. Becker-Weidman used the Vineland-II instrument to assess “adaptive behavior” (Becker-Weidman, 2009) in the children. The Vineland Adaptive Behavior Scales-II specifically measures “adaptive functioning in the following domains: communication, daily living skills, socialization, and motor skills” as well as overall “adaptive functioning and a maladaptive behavior index rating” (Becker-Weidman, 2009, 139). Becker-Weidman cited Sparrow et al. 2005 with use of the maladaptive behavior index of the Vineland Adaptive Behavior Scale. Sparrow et al. (2005) developed “a composite of internalizing, externalizing, and other types of undesirable behavior that may interfere with the individual’s adaptive functioning” (Sparrow et al., 2005, p. 3) in the development of the Vineland Scale. Developmental differences were found between foster children, those who were adopted and children who had always had a secure home. The results indicated that traits consistent with RAD are mostly seen in situations with children who have not had a constant and secure living
situation, have not had healthy attachments with their caregivers, or have been neglected. Becker-Weidman (2009) reported that “adopted and foster children with psychiatric diagnosis of reactive attachment disorder show developmental delay in domains of communication, daily living skills, and socialization” (p. 137). A conclusion made in the study was that older children are more disturbed than the younger children. This was attributed to instability in their lives over the long term period rather than a short term period. On average, older children had “a lower mean adaptive behavior composite standard score…as well as a higher mean maladaptive behavior index and higher mean internalizing and externalizing scores” (Becker-Weidman, 2009, p. 152).

Researchers discussed the typical behavioral and emotional characteristics displayed by children with RAD. For example, Boekamp (2008) focused on one specific case of a child with Reactive Attachment Disorder. In this case study, a child was removed from his or her family because of abuse and neglect; the child was aggressive, violent, and antisocial and took little interest in others or caregivers while in the foster care system. However, when adopted, the child began to freely interact with peers and caregivers with an indiscriminant approach. These traits were congruent with the DSM-IV disinhibited and inhibited subtype of RAD. This was a specific example of the mixed group subtype. The child was then diagnosed and treated for RAD. With long term treatment, the child demonstrated positive emotional and physical behavior changes. The article addressed the use of DSM-IV theory in the diagnosis of the child, however it did not provide specific information about what the treatment of the child entailed except to suggest that parents learn ways to help them teach these children appropriate coping behaviors. While the case study gives hope that some children may be able to recover
from the psychological affects of unstable attachments, the article left out specific information about how to reach this goal. As treatment and intervention are the primary focus of this thesis, lack of specificity in these areas was a major limitation. This short article provided a specific case study example to assist in recognizing characteristics of RAD but little on considerations for how to apply a therapeutic approach and treatment plan.

Children with RAD are difficult to diagnose because they display such a wide range of symptoms. Diagnostic tools used to diagnose RAD contain broad categories related to symptoms. Minnis (2006) reported a qualitative study that addressed relationship building with children who have the characteristics of RAD, the classifications of RAD behaviors, and a comparison of DSM-IV diagnosis with ICD-10 diagnosis. Most of Minnis’ longitudinal research occurred in an orphanage in Guatemala where she observed children for many years. The article discussed the model’s diagnostic materials for attachment disorders. Along with discussion of the model of attachment, this article called for a change in name to make the disorder more specific and less subjective. The author argued that the name RAD is too general and acts as an umbrella diagnosis, which covers many different aspects of attachment.

Minnis (2006) presented an argument for increased focus on social disorders in reference to attachment disorders. Minnis discussed the problem with generalized diagnosis of RAD and the behaviors that accompany the disorder. One large characteristic seen in children with RAD is their inability to function normally in social situations. Minnis (2006) argued that it is important to take this social aspect into account when diagnosing because that is a vital aspect of relationship building. Minnis argued
that work with increased socialization should be a main intervention and that the social struggles are the most typical presentation of RAD. Within the study, one can see how experts clinically diagnose those individuals with RAD. Minnis (2006) provided an in-depth explanation of diagnostic criteria for RAD, the characteristics of RAD, and the different subtypes of RAD. Minnis argued that RAD is a disorder, which desperately needs more attention and focus from researchers.

**Treatment Interventions**

Treatment interventions can be lengthy and there is yet to be one accepted method of treatment. Cornell and Harmin (2008) conducted a meta-analysis from a variety of databases on attachment formation. They explained the attachment theories of other researchers, reviewed results from case studies, and looked at the identification process of RAD along with its treatment. The authors discussed child/parent attachments and treatment interventions (Cornell & Harmin, 2008). This article aided in finding more direct sources of studies on RAD and provided a general overview of knowledge on the subject of RAD. The article also addressed the nursing role in diagnosis and treatment of children with RAD. It was reported that “prenatal visits and well-child visits are two common points of contact that nurses can use to identify families at-risk or already struggling with attachment problems” (Cornell & Harmin, p. 38). In addition, after identification of these problems, nurses play a care giving role during both outpatient and inpatient treatments (Cornell & Harmin, 2008).

Attachment theory suggests that babies are predisposed to form secure attachments with their caregivers during their first interactions with their primary caregiver. Leiberman suggested that those children who have been treated in an
institutional setting prior to being adopted thereafter experience continued attachment disturbances. The cause stated was a lack of trust between the child and his or her adoptive parent (Leiberman, 2003). Hardy (2007) argued that effective treatment for children with RAD focuses on ideas of developmental psychology and those of neuropsychoanalysis. Hardy examined selected literature on RAD and worked to analyze attachment theory as well as treatment for RAD. This research study utilized a case study approach and developed major analysis of the treatment modalities that took place. The author stressed that behavior modification is the highest priority in treatment. Hardy argued that having the caregiver, if possibly, act as a part of the child’s therapy can drastically contributes to a positive treatment outcome.

**Family Therapy**

Keeping the family involved in any therapy is vital to the treatment outcome. Green, Stanley, and Peters (2007) assessed attachment representations measured by the Manchester Child Attachment Story Task (MCAST), atypical parental expressed emotion (EE), maternal mood, and parent and teacher rating of child behavior in children aged 4-9 diagnosed with externalizing disorder (Green, Stanley, & Peters, 2007). Externalizing disorder is thought to be closely related with attachment malformation. This study also used Strange Situation procedure, and classical attachment theory concepts were used (Green, Stanley, & Peters, 2007). Adequate correlation was found between attachment disorganization and externalizing disorder. This means that there was a trend between disorganized or disrupted attachment and the occurrence of externalizing disorder.

**Institutionalized Care**

Environment is noted to have a great impact on childhood development. Several
factors seen in children raised in institutions are that they were at dramatically increased risk for a variety of social and behavioral problems, including disturbances in attachment. Zeannah and Carlson initiated a study done in Romania where there was a low caregiver to child ratio (Zeannah & Carlson, 2005). Zeannah and Carlson “examined attachment in institutionalized and community children 12-31 months of age, in Bucharest, Romania” (Zeannah & Carlson, 2005, p. 1015). They assessed attachment by using a rating scale of caregiver descriptions in an interview setting. The results indicated that children who were raised in institutionalized settings “exhibited serious disturbances of attachment assessed by all methods” (Zeannah & Carlson, 2005, p. 1015). This is important to acknowledge because many of the children who exhibit RAD symptoms are in institutionalized settings. An important contribution this study also provided was “the demonstration that the quality of the care giving that the child received in the institutionalized setting was significantly related both to the continuous rating of attachment and to the child’s organization of attachment” (Zeannah & Carlson, 2005, p. 1025). The attachment of children within a facility depends on the care provided by the staff.

Zeannah and Carlson (2005) discussed presentation of attachment disorders in an institutionalized setting. Researchers found that the prevalence of attachment disorders in institutions is high for two reasons. The two reasons indicated in this study were the ratio of child to caregiver in a facility and specific assessment for RAD characteristics among subjects. The study included children from an institutionalized setting compared with children from families who attend childcare for a period of time during the day. The authors utilized the Strange Situation Procedure to assess the attachment of children to
their caregiver. Strange situation is a test in which the child, along with their caregiver, is exposed to a situation they are not used to. The test assesses the child’s trust and comfort level with their caregiver. A rating scale was developed to document the behaviors exhibited by the children during the assessment. It revealed that children with attachment problems did not react the same in the strange situation with their caregivers as children who did not have attachment problems.

Van Ijzendoorn and Bakermans-Kranenburg reported the similarities and differences between clinical attachment disorders and causation of disorganized attachment. The authors stated that just as abuse affects attachment abilities, residential care can also be the cause of disorganized attachment formations for children (Van Ijzendoorn & Bakermans-Kranenburg, 2003). Van Ijzendoorn and Bakermans-Kranenburg identified that being in an institutionalized setting can add to effects on attachment styles. This thesis questioned bonding and relationship formations of caregiving nurses with children affected by attachment disorders and looked for successful interaction outcomes.

**Caregivers Building Relationships**

Learning to form relationships with caregivers is a vital piece of children’s abilities to learn proper social interaction. Laybourne, Anderson, and Sands (2008) performed interviews or surveyed caregivers of children with RAD in foster care setting and asked them to discuss their experiences. The study contained quantitative data in reference to the comparison of pre- and post-program rating on stress score, parental distress score, total difficulties, ICQ, and RPQ. ICQ refers to Intervention Care Questionnaire and RPQ refers to Relationships Problems Questionnaire. A “marked
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decrease in post scores was observed for both questionnaires, when compared to pre-programme scores... it is worth noting that all post programme results, when compared to pre-programme results, had moved in a positive direction. This indicated that there was success in the programme. Many children who enter into the public system have or develop attachment difficulties, “which are understood to be at the root of many emotional and behavioral difficulties” (Laybourne et al., 2008, p. 64). Laybourne et al. (2008) focused on behavioral and emotional testing and recognition skills of staff members. Laybourne, Anderson, and Sands (2008) had focused on the staff’s ability to identify the concerns of children with RAD with a history of abuse and neglect. The study outlined the training program for caregivers for these children. Most of the study was directed at foster care situations, but in a long-term hospitalization situation, these ideas can be applied to creating and building a healthful relationship between the individual and the nurse. The methodology involved sampling caregivers and providing them with extra, in-depth training. The training included stress reduction techniques and testing approaches. This article brought forth many different aspects of care for children with RAD that could be directly applied to the nursing interventions necessary to promote healthy attachment.

Research indicated that familial trauma has a direct link to the development of disordered attachment and psychological problems in children (Hughes 2003). Hughes discussed familial trauma as a precursor to attachment disorders. His main focus was on therapy for the patients affected by attachment disorders. He acknowledged the “lack of consensus regarding the definition of attachment disorder as well as the means of assessing it” (Hughes, 2003, p. 272). Hughes explained that treatment for attachment
disorders should begin with the coalition of the therapist and the family agreeing upon strategies to aid in the attachment process. He further suggested that “the concept of ‘intersubjectivity’, which is being developed both by developmental attachment and psychodynamic theorists, will have an important role in efforts to assist children and youth with an attachment disorder” (Hughes, 2003, p. 274). Hughes indicated that intersubjectivity of the child mirrors that of the caregiver. Those who have been traumatized by their parent or caregiver have a traumatic attachment with that person. Before healthy relationships can be formed, the traumatic experiences need to be addressed. Several different styles of therapy are presented through Hughes’ research: behavioral therapy, family therapy, communication facilitation and nonverbal communications are all essential in attachment formation. Touch, facial expression, and eye contact also play a role in displaying the child’s comfort level with his or her caregiver during attachment therapy. The focus of attachment therapy falls within the child’s ability to adapt to different styles of attachment formation (Hughes, 2003).

Hughes (2003) discussed the process of attachment formation and emotional recovery with children who have had disturbed attachment. Hughes emphasized the need children have for a stable attachment with their caregivers and the importance of reestablishing this trust especially in foster care situations and adoptive families seen in his works. Hughes’ focus was on the effects that trauma has on these children in later life and relationships. Trust and abnormal behavioral issues will always be present with these affected children (Hughes, 2003).

**Fostering Attachment**

Cline discussed her experiences in dealing with children affected by RAD as a
nurse manager on a behavioral psychiatric unit. Cline explained that, for whatever reason, children with RAD have been altered in their ability to form relationships with others. She examined 12 case studies of children with RAD who had been on her unit and discussed characteristic behavior and treatment modalities related to each case. This specific study referenced nursing interventions and the struggles the staff face while working with children diagnosed with RAD. Although Cline addressed many points in her article and gave many firsthand examples, she was only able to produce case studies as support to her ideas. She did, however, assure the reader that the main nursing interventions for children with RAD are perseverance and patience.

Attachment refers to emotional and social aspects of behavior related to relationships. Wilson (2009) reported findings on psychiatric and psychosocial issues related to children and adolescents. The qualitative study focused on the formation of the correct attachment between the child and the caregiver. The article described techniques of attachment that promote healthy and positive relationships. The purpose of Wilson’s study was to explore early relationship building in relationship to attachment theories. This is imperative to include in the research by Wilson as the nursing relationship continues throughout treatment. One weakness is that the study was rather short, and even though it was well researched, it contained only two treatment options. Significant findings in Wilson’s study included the patterns of attachments and the discussion on caregiver’s roles. These ideas are extremely important because the nurse plays the role of caregiver during the relationship with the client, and this article provided concise teaching on formation of attachment.

Summary

The literature indicates that there is still much to be learned about attachment
disorders. Attachment disorders were only recently reclassified in the diagnostic manual of the DSM-IV and DSM-IV-TR. In addition, diagnosis of attachment disorders is difficult because of overlapping symptoms with other more common behavioral disorders. The development of RAD is mainly related to ineffective attachment formations in the early years of childhood either through displacement, neglect, and/or abuse. The research reviewed suggested that those who work as caregivers of children affected by RAD play a vital role in that child’s eventual ability to learn attachment styles, trust, and social skills. Treatment of RAD is long term and cannot be charted on any linear scale (Cornell & Harmin, 2008). Improvement with relationships or results may never be seen by some caregivers working with children with RAD. Each child presenting with RAD may suffer from different discrepancies in their social and behavioral abilities. Most available treatment or methods of therapy involve the caregiver and work with trust building and the formation of healthy attachments and relationships with adults and peers. This thesis examined the experiences of nurses working with children affected by RAD and the struggles the nurses have dealt with in an effort to form safe and healthy relationships for these children during the treatment process. Many researchers acknowledge the lack of research on the diagnosis of Reactive Attachment Disorder. No research is available on specific care practices or guidelines for psychiatric nurses working with children diagnosed with RAD. There are also no studies which address the mental and emotional stress psychiatric nurses experience in their work. There is a great need for more research in this area. The research question of this thesis asked, how does the psychiatric nurse develop a safe, treatment-centered relationship with a client diagnosed with RAD within the pediatric psychiatric setting?
CHAPTER III

Methodology

Grounded theory methodology was selected to answer the research questions related to how psychiatric nurses develop a safe, treatment-centered relationship with a client diagnosed with RAD within the pediatric psychiatric setting. Grounded theory is a qualitative methodology in which a theory is discovered through the analysis of data obtained by research (Fain, 2004). According to Glaser and Strauss (1967), “generating a theory from data means that most hypothesis and concepts not only come from the data, but are systematically worked out in relation to the data during the course of the research (p. 6). Within this thesis, a theory emerged through themes within the experiences of psychiatric nurses working with children with RAD.

Grounded Theory

An important aspect of grounded theory is its exploration of symbolic interaction. Symbolic interaction discovers social interaction between individuals. Fain (2009) described it as the following:

Basic principles central to symbolic interaction include the fact that human beings act in relation to one another, take each other’s acts into account as they themselves act, and provide meaning to specific symbols in their lives. (p. 219)

According to Glaser, grounded theory “is the systematic generation of theory from systematic research. It is a set of rigorous research procedures leading to the emergence of conceptual categories” (Glaser, 2008, para. 1). Symbolic interaction is a key component of grounded theory methodology and fits well with the research question. The research was analyzed using a constant comparative methodology. Glaser described this in four stages: “(1) comparing incidents applicable to each category, (2) integrating
categories and their properties, (3) delimiting the theory, and (4) writing the theory” (Glaser, 1967, p. 105). Research will be incorporated from articles and from the one-on-one interviews with four psychiatric nurses.

**Researcher’s Bias**

The researcher is employed at a pediatric psychiatric hospital and has worked in the role of a Mental Health Technician (MHT) for children with RAD. The researcher has observed the health care team interact with children with RAD. From experience, this researcher has seen the effect of nursing or caregiver relationships on a patient’s social abilities. The researcher will analyze the data with the Honors Thesis Director to prevent bias or judgment from interfering with the data analysis process.

**Characteristics of Participants**

The sample of the study included four psychiatric nurses who work at a local pediatric psychiatric hospital as unit managers. Participation in the study was voluntary. The information was collected in an audio taped private interview style. The setting of the interview was in a place, which was agreed upon by the experimenter and the subject. Participants in the study were qualified psychiatric nurses working at a child and adolescent psychiatric facility. Participants were required to have worked in psychiatric nursing positions for at least 2 years and have experienced working with individuals with Reactive Attachment Disorder. There were three female and one male nurse invited to participate in this study.

**Ethical Considerations**

The Carroll College Institutional Review Board approval was obtained prior to initiating the study and carrying out the interview process. Training for Protection of
Human Participants by the National Cancer Institute was completed online prior to data collection. Any information obtained through interviews or information about the participants themselves was kept confidential as names were not included and information was stored in a secure place. Participants’ names, ages, and genders were kept confidential; individuals are identified as participants in the study. Informed consent was obtained prior to data collection [Appendix 1]. Interviews took place in a private, mutually agreed upon setting.

**Data Collection**

Data was collected by in-depth audio taped interviews with the participants. The researcher asked for them to volunteer for this study and explained what the purpose of the study was. The participants were asked the same questions prepared by the interviewer [Appendix 2]. The main focus of the interview was to discover the style in which the participant had developed a safe, treatment-centered relationship with a client diagnosed with RAD within the pediatric psychiatric setting. During the interview, the researcher made important notes about body language and facial expressions of the participants.

**Data Analysis**

Data was analyzed by using the classic grounded theory by means of the constant comparative method. This is a form of qualitative data analysis used to sort and categorize the data by comparisons until obvious concepts can be developed and supported (Fain, 222). The experiences of the four nurses were examined for similarities and differences as well as for techniques of relationship building that worked well versus those that worked less well. The theory on methods to improve interaction between
children with RAD and their caregivers was deduced through a thorough comparison of behaviors displayed by individuals with RAD in the examples provided by the participants, as well as their relationship building strategies. This theory was developed from congruent themes found within the transcribed interviews.
CHAPTER IV

Findings

The following are the research findings from the grounded theory analysis done using the experiences of three participants who have worked as nurses in a children’s psychiatric facility and their experiences with children with RAD. The core theme identified was “Developing a Relationship”. Within this core theme, five supporting categories were developed based on a social process derived from the similarities between each nurses’ experiences working with children with RAD. The categories included: “getting to know the patient”, “setting boundaries/relationship facilitation”, “developing trust”, “running into resistance”, and “changing approaches.” The five supporting categories were called phases, where each phase represents a supporting category. Other themes which participants emphasized were “Recognizing Personal Weaknesses,” or the nurses’ ability to objectively work with a patient while taking care of themselves, “Knowing their Behaviors,” or recognizing the characteristics and expected behaviors of children with RAD, and finally “Initiating therapy,” when the relationship is formed successfully.

A basic social process was identified in the core category of “Developing a Relationship.” The model includes the process for relationship building in the therapeutic setting. The model includes a total of six phases. Phase one of the social process consists of getting to know the patient but being deterred by roadblocks. Phase two requires boundary setting and establishing the nurse to patient relationship. Phase three includes developing trust. Phase four is running into resistance where a problem or misunderstanding may occur in the relationship. After phase four there is the deciding
factor, the question “Is there a successful trusting relationship formed?” The formation of a therapeutic relationship is a unique process between two individuals and has very individualized phases. Phases four and five are optional phases and are experienced during times of resistance. Phase four, running into resistance, occurs when the relationship process is hindered by social obstacles. This may cause the process to begin again or continue to phase five. Phase five allows for change of approach. Phase five is not experienced in all relationships. Phase six would include a complete rebuilding of the entire relationship, starting over at phase one. The process in which individual children will move through these phases is highly variable. Throughout the process, empathy, reassurance, consistency, and unconditional positive regard are four essentials which allows for insight into the clients’ behaviors as they transition through the phases of Developing a Relationship.

**Core Category: Developing a Relationship**

Developing a relationship with children who are diagnosed with or possess traits of Reactive Attachment Disorder (RAD) is extremely difficult. It is a lengthy process involving trust, consistency, empathy, reassurance, and patience. The time it will take for a therapeutic relationship to form depends on the individual child. Each of these will be described and validated using quotes from participants.

*Phase One: Getting to Know the Patient.* Participants reported that getting to know the patient is the most important aspect of forming a therapeutic relationship. However, it takes time. In reference to forming a relationship one participant stated:

> It takes time. It takes time to just get to know that person first. I think taking some extra time on the front end of developing a therapeutic relationship just to get to know that person, not to dive into anything but just to get to know them. You know, just like “How’s it going? What do you like? Oh, that’s cool.” Just getting
those things out of the way, and it may take, I don’t know, it may take a long time. It may take weeks. It may take a bunch of conversations to get past the…I guess developing trust part of it.

Participants stated that the key to developing a trusting relationship with the patient is through empathy, positive regard, and reassurance. Participating in activities with the patient or showing interest in learning about the child’s hobbies can form a commonality between the nurse and the patient, which may aid in relationship formation. Following the same idea, another participant stated:

Oh, you know trying to find something that they are interested in, a particular hobby or if they have pets, you know, again sort of watching their affect and seeing if something sparks them and then just staying with it. You know, if it’s something that you’re thinking about or worried about, lots and lots and lots of empathy, lots of reassurance. Humor, for sure, as long as it’s not sarcastic, and very simple, sort of straight forward. You know, having a very gentle attitude, having a very accepting sort of manner, that kind of thing.

Creating a relationship with children who have attachment problems is best done slowly, consistently, and comfortably.

Along with making an effort to allow conversation through comfortable and neutral settings it is important to be able to meet patients where they are and have some understanding of their social abilities. One participant shared:

I think certainly being informed about the psychology of trauma, because these kids have been traumatized. So understanding the impact of trauma on brain development, impacting the understanding of trauma on, you know, emotional and social development, and then being really able to meet these kids where they are.

It is not enough to be able to understand and recognize the behaviors of these patients but the nurse also must know how to connect with them on a therapeutic level. There is not one specific way to go about making this therapeutic connection. One participant said:
I was always afraid that I was going to say the wrong thing … Then I realized that I was trying to say something that I wasn’t and use fake words, and it just seemed so fake that I don’t think that they responded well to me until I started to be, you know, really talk as it is.

Being able to provide empathy to patients with RAD allows the nurse to gain insight into the patients’ behaviors and how they respond to certain situations. It is a very individualized type of care. One participant described their experience working with children with RAD:

I think I am adjusting my approach, frankly, for every individual I come across because there is no cookie-cutter approach that is going to work. And it might… when one approach might work with a kid one day is not going to work the next day, or might not even work that afternoon or five minutes later. I mean, it really is being very, very in tuned to where that child is and learning to trust, you know, learning to develop that sense of empathy where you can really very quickly sort of put yourself in that child’s place and see the world through their eyes, which is so important because you have to understand in order to deal with it, and you have to understand in order to help them interpret because so many of them distort, and you know, they have their own issues with trying to determine what is real and what isn’t real. I think I’m constantly adapting to what the child needs at the time. With RAD kids, I am probably even more slow and reserved about how I approach them because so many things can be misinterpreted by these kids so easily. And so I keep my voice modulated, I keep my movements, my you know, para-verbal language varying, low key, again to make things safe and low-stimulus as possible but not distinct, usually very easily over-stimulated. They haven’t developed those internal mechanisms of self-protection. They just don’t have them. You know they’re like a turtle without the shell. So you have to, even in your own self, create a protective sort of bubble for them immediately within the relationship.

After getting to know the patient and what they need, the therapeutic relationship begins.

In continuing the phases of Developing a Relationship the next phase requires Setting Therapeutic Boundaries.

**Phase Two: Setting Therapeutic Boundaries.** Setting therapeutic boundaries means that during the formation of the therapeutic relationship between the nurse and the
patient, specific boundaries are established. These boundaries may refer to physical boundaries or “personal space” and boundaries for touch as well as discussion topics.

One participant stated: “You’ve got a line that you can’t cross”. Therapeutic boundaries are put in place to protect both the patient and the nurse. Establishing initial boundaries with the patient allows the nurse to be consistent and maintain a level of safety and comfort for the patient. One participant discussed teaching boundaries to patients:

I think, of course therapeutic boundaries are probably one of the most important things in developing a relationship with any patient; specifically, you know, an adolescent who may not, you know, understand those boundaries, may have had inappropriate boundaries throughout their life. You know, obviously they may have been abused or neglected and you know, that can highly factor into what you understand about boundaries. So I think that’s one important key to developing a relationship with one of my patients.

Another participant stated:

Trying to balance being a professional and being therapeutic with coming down to their level. Not that they’re like on a lower level, but you know, adolescents speak differently, they obviously think differently. You know their frontal lobes aren’t completely developed, you know, so even their view of life can be a little bit different, so sometimes coming down to that level, even speaking their language, using words that they might use to help them understand, you know, what you are talking to them about. I think it has been really helpful for me, and it’s learned too.

Putting the nurses expectations into terms that the patients can understand is essential to the patient being able to successfully meet that expectation. Boundaries must be enforced and be very clear to the patients. One participant shared:

You know, that’s an interesting thought on our personal boundaries. Some people, you know, we can hug people here of course. And we do. We do a lot of the smaller kids and sometimes it’s inconsistent when we notice somebody who is going to hug you and not let go, and then that’s an uncomfortable feeling, so you set that limit and say “No, I don’t hug you. I do handshakes,” and then another person you’re hugging. So it sends a mixed message to people, but then it comes back to that consistency.
Being consistent about what types of touch are acceptable and the types of conversations that are acceptable. A participant said in reference to children with RAD:

It’s just that boundary issue that they have. You know, some of the kids, they will come up to anybody and anybody and hug them. You know, kiss them, try to kiss them, whatever. They don’t know when to draw the line, and some of them just have such a hard time with a relationship with anybody.

As nurses working with children who have been diagnosed with this disorder it is imperative that we tailor our care to their personal needs. While the care that we provide to these patients is different than the care we may provide to another it is important to recall that this care must be provided with the thought of the patients diagnosis and history. One participant stated:

It’s easy to I guess get yourself overly involved in, you know, a patient’s problem or their history, or their projections when really, I think, it’s more important for us to just be a tool therapeutically for a patient.

It is essential to learn significant things about a patient or their history yet also is essential to maintain safe and consistent therapeutic boundaries. If this is done, nurses are able to use themselves as a therapeutic tool in the process of treatment for children with RAD.

Phase Three: Facilitating a Trusting Relationship. Following development of a trusting relationship and setting boundaries, it is important to continue to facilitate the relationship. Forming and maintaining a relationship with children with RAD requires long-term commitment. Getting to know the patient first eases discomfort. One participant pointed out that:

You know, in just getting to know the patient you get to know, you know, the things that they like, their hobbies, maybe, maybe even their religion or things that they believe in. Sometimes it’s okay to strike up those type of conversations as long as you are not like giving too much away of yourself, you know, of getting too overly involved about yourself. I know there was a patient that we did, you know, certain activities with, like maybe we’d go play hack together. It was
something that he really liked to do. And so that was a time to build trust. It was a time to strike a conversation.

Participating in an activity with the patient that the patient enjoys can help to build a commonality between the nurse and the patient. Building trust can be challenging and take time. The responses by children with RAD are variable and a nurse must be sensitive to this. One participant shared:

Well, these kids are hard for us to attach to, right, because they give such odd responses. Sometimes their behavior is surprisingly over-attached to you or they’re very, very aloof. Their responses to situations and people sort of fall outside of what you would normally expect, so it could be a little bit jarring sometimes because you’re…the behaviors that you’re sort of accustomed to, you know eliciting a certain response, with these kids it doesn’t elicit the same response so you have to really be very, very… tuned to their responses and their perceptions and things and keep, I think with these kids especially, again, not that this is important with all psychiatric patients and children, but that rational detachment is very, very important to develop because they can be so difficult to understand…

Being able to portray to the patient that the nurse cares yet being able to not become personally attached is extremely important in the formation and continuation of a therapeutic nursing relationship. Trust is formed in many different ways. Use of essential nursing practices in relationship building is vital. These nursing practices include empathy, reassurance, consistency, and unconditional positive regard to be discussed at the completion of the phases.

**Phase Four: Running into Resistance.** Resistance in the formation and maintenance of a relationship is found in many instances. One way that nurses run into resistance in relationship building is by not completely understanding the behaviors of their patients and the reasoning behind these behaviors. It is a nurse’s responsibility to recognize the characteristics of certain disorders and know how to approach them. By
knowing the behaviors specific to the patients, nurses can implement interventions when they run into resistance. One participant pointed out:

Yeah. I think there may have been a time when I necessarily didn’t view that diagnosis or those behaviors differently than I did with say maybe bipolar disorder, oppositional defiant disorder, other things like that, but I definitely do view it differently. And I think the more I’ve worked with them, the more I can spot it differently and realize okay, it’s time for me to have this type of approach with that child because I can see those traits.

Having a knowledge base about the characteristics and behaviors that a nurse is expected to see when working with children with RAD is helpful in understanding why these children act and respond the way they do. One participant stated:

I’ve been a psychiatric nurse for 27 years, so reactive attachment disorder was not around when I started. I mean, the symptoms of it were around, so most of what kids would have that or carry that label, I guess, it’s not even exactly an official diagnosis, that carry that symptomatology.

Another participant shared:

I’m working with these kids with this diagnosis or that display those types of traits, and how does it go? It’s “I love you, don’t touch me. I hate you, don’t leave me.” And so it’s…you know sometimes I just say it a couple of times to really grasp what it means, but like I think of that phrase often when I work with these kids. They’re super-challenging. They may be your friend one day, your best buddy, and the next day they may cuss you out and tell everybody you’re the worst person in the world, do really humiliating things. The next day after that it may be something totally different. And it’s unpredictable. I found that often those whom these kids have a relationship with are often targets of their turmoil, their inner turmoil is projected onto them more than people that they just don’t know, more than innocent bystanders or more than people that they might actually have the conflicts with. I’ve just kind of seen that as a pattern.

This relationship building can be difficult with the constant conflict projected by the patient. This calls the nurse to be sensitive to the child’s outbursts and behaviors while consistently reassuring them of their safety and acceptance.
One participant spoke specifically about a case with a young girl in the treatment setting and the process by which relationship formation and maintenance evolved. The participant explained:

I think we’re expecting her treatment to progress very slowly and take a lot longer than other cases just simply for…because it’s difficult to build a therapeutic relationship. It takes a long time. It seems like you see the same patterns of distrust and projections with her and staff members, the same patterns with her and her family. And I’m sure, you know, they’ve dealt with it for years, and you know of course we’ve only dealt with it for months, but it really makes you think like gosh, it must have been super difficult for those parents and I can understand how they might be exhausted and may have felt like giving up a times. You know, again this girls behavior is often unpredictable.

In discussing the patient’s characteristics and behaviors, the participant went on to explain this specific patient’s behaviors and progress in therapy. This participant continued:

I think she often doesn’t have insights into how her behavior effects other people or an insight into those patterns of pushing people away or projecting her inner turmoil on to us, and often she can’t explain…or she doesn’t have enough insight to say that like “I feel really crappy inside.” It’s “I hate you,” or “You’re terrible,” or “This place is awful and I’m going to break something or throw something to show you that.” Or “I’m going to hurt somebody.” It seems like it’s easier to display her inner turmoil or whatever is going on with her by lashing out at people she has a relationship with or people that are close to her than to process through it therapeutically. And so…and it seems like there’s also a pattern of starting to gain some insight, starting to learn how to do things differently, and then dropping back down a level, or maybe, some people call it like “back-sliding,” and so, you know, seeing those patterns. As a team we’ve been okay with thinking that, okay, this might be like…maybe initially we thought this was a two or three month process, this might be a six or eight month process, or this might be a really long process that extends into outpatient therapy into maybe years of treatment. I think you just have to be in it for the long run.

Treating children with RAD can be a long process which a nurse may not see carried out to an end result. One may run into many types of resistance and be unable to form a
therapeutic relationship. This type of treatment may be lifelong learning in relationship building and trust.

*Phase Five: Change of approach.* As a nurse working with children who have behavioral and attachment problems it is important to be consistent in approach but also to be flexible in relationship planning. One participant learned in their experience:

> You know there was a time when you know I kind of tried a more friendly approach with a patient, and you know, it kind of became not helpful. Again there was a lot of that projection and I really had to change my approach to a firm boundary limit setting approach for a time.

Being flexible in the approach of care that the nurse gives to the patient while learning what works for that individual is an important piece of relationship formation. If the nurse approaches the patient one way without success, trying a different tactic can provide success. All patients will respond differently to certain situations and certain environments. One participant explained:

> I think it would have to be super flexible treatment to where you can maybe change your approach from month to month or week to week based on what that child’s needs are, not based on what you do as a program, just because I think inevitably you’re going to run into a lot of resistance probably no matter what treatment modality you are using, so you’d better be able to be flexible but be able to not give up, I guess. And not think that that child can’t be helped, or that they can’t do well, because I believe that they can do well.

Treatment for patients with RAD must be tailored to the individual’s need rather than the protocol of the treatment, some protocols may not work for them. This is where a nurse needs to be a patient advocate and discuss other options with the treatment team outside standard protocols at the facility. This flexibility and ability to use a different technique may mean whether or not the treatment is successful for the patient.
Recalling nursing practices. Using the nursing process and qualities of nursing to provide support to a patient is vital to the formation of a nursing relationship. This practice or these qualities include the use of empathy, reassurance, consistency, and unconditional positive regard. Unconditional positive regard refers to treating the patient in a positive way consistently no matter what the current situation may be. This means that in all interactions with the patient the nurse should employ these strategies in an effort to build and strengthen the therapeutic relationship.

Essential 1: Empathy. Empathy is a vital aspect of working with patients and having a therapeutic relationship. Empathy means accepting the patient and what is going on with them. Empathy includes a deep understanding provided without judgment or expectation. It also means providing them compassion and showing them acceptance of the feelings they have. One participant explained that empathy is directly related to reassurance. The participant stated: “Lots and lots and lots and lots of empathy and reassurance that though she may hate me a lot of days, I don’t hate her, and you know, I think she’s a great person, full of potential.” Empathy is the nurse taking the time to gain an understanding of the patients feelings and why they feel that way. One participant stated:

I think reactive attachment kids, again, it’s a very, very, very slow healing process, much slower than other disorders that I’ve witnessed, so as much of the nurturing, compassionate, quiet days in a caring environment that you can provide in every way is essential for these kids.

As a nurse being compassionate and nurturing is part of showing these patients empathy. One participant expressed that being able to honestly say “hey I care” can be an extremely important way to support patients.
Essential 2: Reassurance. Reassurance is directly related to the interactions between nurse and patient. Participants stressed that the patient needs to be able to form “relationships that can consistently provide a reassurance that they’re, you know, that they’re not going to be rejected, they’re not going to be abandoned, and that we’re not going to give up. I think that’s important.” Providing this kind of support and emphasizing that the nurse cares for the patient and is “not going to give up on you [the patient]” becomes a vital aspect of the nursing relationship with children diagnosed with RAD.

Essential 3: Consistency. Consistency may be the most important aspect of these four traits used in nursing relationship building. Consistency is necessary in order for trust to be built. One participant stated that consistency is “doing what you say that you are going to do.” It sounds simple and obvious but lack of consistency in many cases causes problems with treatment. One participant explained “I think for me and my own personal opinion, I think, you know, staff turn-over is very, very hard, staffing patterns can interfere with those kinds of things” in reference to treatment. One thing that participants emphasized is that patients with RAD form relationships different than others. One participant stated:

You know, we can become close to someone and develop trust and intimacy with someone because we can pretty much predict that when I say this and do this, they are going to react in a certain set of ways. Well, reactive attachment kids don’t. They can react in all kinds of crazy ways, so an understanding of staff about trauma and the effects of trauma on the child in those various ways and then of course consistency, because with reactive attachment kids and traumatized kids in general, consistency is paramount.

Children with RAD experience so much inconsistency that just having a consistent environment and a nurse who responds to their actions in a consistent way daily is
Having consistency can make these children feel safe claimed one participant. The participant went on to state:

They really...they have to develop that sense of safety. They have to know that because their world has been so not consistent, they have to know that certain things happen every day, and that’s where all that structure and front-loading and that comes in.

Safety and structure are essential to creating that nurse to patient relationship needed for treatment of these children.

**Essential 4: Unconditional positive regard.** Unconditional positive regard refers to showing the patient they are accepted and cared for unconditionally and treating them the same no matter what the current situation may be. One participant, when asked what was the most important piece in building a therapeutic relationship answered: “Positive regard. I think unconditional positive regards. And then empathy for sure, sort of accepting them where they are at and however they are presenting to you is good.” This means accepting them no matter what behaviors they are displaying. Unconditional positive regard can be shown through reassurance and empathy but one participant explained that it is “All that talk about, like you know, “I’m not going to give up on you. You’re not rejected. I’m not going to abandon you. I still like you,” you know, those types of things.” Another participant shared what they would say to clients to show unconditional positive regard:

These are the type of things I would speak to her, you know, and that we’re not giving up on you, and that we want to provide treatment to you, you know, we’re not abandoning you. Of course I wouldn’t really say it that way, but those are…I think that’s the type of verbal and non-verbal things that I would want to express to her continually….I think just that consistent reassurance day after day after day after day, that’s what’s helped, and not taking things personally, in the moment and later on as, you know, I’m processing things with her.
Recognizing that the things that patients say typically have little to do with the nurse and more to do with their internal trauma is an important aspect of being able to provide this unconditional positive regard. It is difficult for a nurse to be supportive and caring towards a patient who is yelling at them if they are not able to recognize this. The nurse must be able to keep their personal emotions out of these situations. It is important for the nurse to recognize personal weaknesses in order to keep one from becoming emotionally involved in a patient’s case.

**Recognizing Personal Weaknesses**

Participants identified issues with their personal life that inhibited the therapeutic relationship. A consistent word of advice was that one must be self-aware in order to be therapeutic with these children. Using yourself as a therapeutic instrument for these children requires that one not take anything said or done by the child personally and to recognize that nothing that the children may say or do is directly related to one’s presence. Knowing one’s limit with patients and recognizing when one has become too involved is important as well.

One participant described their role as a nurse working the children with RAD. The participant was adamant about differentiating between the nurse’s role versus the role of the therapist as an important piece of the team approach of treatment. The participant also emphasized that being comfortable with the nursing role as a therapeutic tool is a key factor in relationship building:

My role was to be the nurse, not really to be the therapist, so there were certain topics that I steered clear of and maybe I’d guide the patient or whoever to have that in a different setting behind closed doors with, you know, the appropriate professional. I don’t know, I think I’ve used those techniques lots of times just to show that I wasn’t a…you know, like a big dork, like I could actually relate a little bit, and maybe if I couldn’t relate I would fake it. Right. It’s okay to fake it
too. They may think you’re a dork and they may see through you, but I think especially an adolescent appreciates that.

In order to be able to connect with children with RAD the nurse must to be able to dedicate all interactions entirely to the patient and know their role. This means that the nurse must be confident in their abilities to the extent where they can use their actions as the therapeutic tool. Participants emphasized that they have to remember that the relationship is not about meeting their needs, it is a therapeutic tool to meet the needs of the patient. It is important to make sure that none of the interactions with patients are about meeting the nurses own needs but rather are solely for the benefit of the patient.

The treatment must solely be about their needs. One participant reported:

I think that more than anything probably our own feelings get in the way sometimes, that rational detachment is a skill and it’s not an easily learned skill for many people. I think so much has to be about the child and not about us that I think those kinds of issues really can interfere with the kids’ treatments.

Participants discussed the importance of not allowing themselves to take things said or done by patients too personally. One Participant explained

I think as a nurse, taking things personally, even if you’re…even if that’s maybe your personality to sometimes take things personally, that can be very dangerous and not helpful in a treatment for one of these patients, thinking that, you know, you’re the…taking too much of the burden on yourself, I think, maybe by thinking that you’re the only one that can help this person and you’ve invested so much. Having that type of mentality I think is very dangerous too.

Taking care of patients with RAD can be emotionally as well as physically draining. One participant said “It’s easy to I guess get yourself overly involved in, you know, a patient’s problem or their history, or their projections when really, I think, it’s more important for us to just be a tool therapeutically for a patient.” Making sure you are meeting your needs outside the work environment enables you to provide the best care possible to your patients.
Knowing Their Behaviors

In addition to the ability of recognizing personal weaknesses a nurse must also recognize the traits and typical behaviors associated with RAD. The participant continued:

Of course all the kids can be challenging, but I think specifically these kids can...if you don’t care for yourself enough and if you don’t set appropriate boundaries, you can get really tired and worn out, and be thinking about that child and what’s going on too much. So I think self-care is really important in that aspect. I think also not taking things personally, like I said. They can target you and project things on to you, but just to remember that, you know, you’re a professional. It’s about them. It has nothing to do with you.

A nurse working with a child with RAD must view small steps forward as progress towards a positive outcome. One participant stated, “I think just the major things I’ve learned is that success is measured really small, and that it’s not easy.” In order to provide any kind of effective treatment you as a nurse must be invested in the development of a relationship with your patient. Nurses working with a child, with RAD must have an understanding of their behavior and their diagnosis. One participant said:

I think certainly lack of understanding of staff because it is a difficult problem to kind of wrap your head around. I think more education about it, like I referenced about it before is essential. I think these kids can push our own buttons, and so self-knowledge and self-awareness is essential because you can’t...you don’t want to further traumatize the child, so not everybody can do that. We like to project a lot of our own feelings on to these kids without realizing it because we want something to be there that might not be there. That’s very difficult in working with RAD kids.

In order to take care of emotionally unstable children, the nurse must be able to achieve an amount of emotional stability and allow patients to freely express their frustrations and feelings without taking it personally. It takes a lot of care on the part of the nurse to
provide a therapeutic relationship for children struggling with this amount of social ineptitude.

**Initiating Therapy**

Treatment for children with RAD is different depending upon the amount of abuse and neglect that the child has been exposed to and their capability to form relationships. RAD is commonly seen in primary or secondary diagnosis. One participant explained:

We see a lot of kids that have a diagnosis of reactive attachment disorder. It’s a common diagnosis but it’s not one that I say we see, you know, every week we get a patient like that. But there are many kids that come in through the doors that have RAD as a primary or secondary diagnosis.

While RAD is a common disorder, one participant shared:

I don’t know what’s helpful for the RAD kids because they are so damaged. They’re here for a very long time usually, on the whole...just sort of rebuild their social structure. And I just think, you know, there’s a lot of therapy that goes behind this and a lot of time that passes to be able to start forming a relationship with people, just the start of it. You can work at it for a year and they can just have a start at that point.

Children with RAD can be extremely challenging to reach on a therapeutic level.

Reaching this level involves the comfort and trust of the patient with the nurse. Reaching this level is also very dependent on the patient and their abilities or desire for a relationship. One participant discussed a relationship she and her staff had formed with a young boy and she said:

Not relationships in the traditional sense, like they went back and forth, but he would tolerate their presence, I suppose that was his best thing. And we were all sort of just knocking our heads out to think how are we going to reach this kid because we had had him for a while and we sort of could see that there was somebody in there, right...there was someone who wanted to know us, who wanted to be comforted. I mean this is a kid that was really suffering inside his
own shell, and he couldn’t… he just couldn’t, you know, get it together to reach out to us. No matter what we did, it wasn’t going to work.

This inability to form a productive relationship with nursing staff is not uncommon with children who display traits and behaviors associated with RAD. Children with RAD have difficulty learning to trust others enough to form a working therapeutic relationship.

When asked what a successful relationship with a child with RAD would look like, another participant summed up what it is to have a relationship with a child who has experienced the serious attachment aversion which occurs with RAD:

I think a successful relationship is the relationship that can stay within comfortable boundaries for both people. A relationship where there is enough trust that any risk or conflict within the relationship, no matter how small, whether I made them a ham sandwich instead of a turkey sandwich, doesn’t cause a melt down and doesn’t cause a fracture in that relationship. These kids, their primary relationships were fractured, and so they continually have relationships that are easily fractured. Their ties to other people are so tenuous that the slightest risk destroys it, and then it’s almost like you have to start over rebuilding it. So a healthy relationship with an RAD kid would be one where there is enough trust built up that they can withstand the little things that we wouldn’t even probably notice, the little ups and downs, the little conflicts that can occur on a day to day basis in a relationship and not be devastated by them. They still might be upset by them, they might over react to them the way… more than a normal child would, but it wouldn’t destroy them. And if you’ve ever seen these kids, they are destroyed by differences and conflicts. So a healthy relationship with an RAD kid I think would be one that could withstand these small little problems on a day to day basis.

One may never know if a therapeutic relationship is successful and helps that child to overcome their problems with social interaction. However, through the interviews of the participants the creation of the model “Insight into developing a therapeutic relationship” occurred.
CHAPTER V

Discussion

The research question of this thesis was “How does the psychiatric nurse develop a safe, treatment-centered relationship with a client diagnosed with RAD within the pediatric psychiatric setting?” A relationship-building model (“Insight into Developing a Therapeutic Relationship”) resulted from the analysis of the interviews done with psychiatric nurses working with children diagnosed with RAD who reside in an inpatient setting. The first three phases of the model, “Insight into Developing a Therapeutic Relationship”, which are vital to the formation of a therapeutic relationship, are similar to the processes used in building an everyday relationship. The first phase includes getting acquainted with the individual. The second phase involves the setting of boundaries by both individuals to create a comfortable environment for the therapeutic relationship. In the third phase, trust is developed between the two individuals. There is an absence of research available which focuses on the development of trust in children with attachment problems. Mary Ainsworth, an attachment expert who has spent twenty years studying attachment called for further research in several areas including trust formation. Ainsworth stated that those who “in inspiring trust, may provide a secure base from which the person may gain confidence to explore and reassess his working model of relationships and, equally important, his working model of himself” (Ainsworth, 1985, p. 810) ought to be included in studies of attachment. For the average person, steps in trust building appear simple and can occur quickly. For a child with RAD, these steps can take months to years to develop and may be influenced by the different people involved in their treatment. Additionally, Ainsworth called for research on caregiver roles within the
context of attachment. She stated “Nor have we mentioned a child’s relationships with parent surrogates … who may play an important role in his life, especially those who find in them the security that they sought but could not attain with their own parents” (Ainsworth, 1985, p. 810). Still today, there is no current, extensive research in which major conclusions regarding relationship formation between children and their caregivers have been identified.

After any relationship is formed, there will be conflicts at some point. Typically, people are able to work past these conflicts while still retaining the relationship and essential trust. In children with RAD, the relationships they are capable of forming are volatile. If the nurse cannot meet the child’s need correctly, or for some reason, the child does not feel safe, the relationship may “run into resistance.” If resistance occurs, it is imperative that the trust be reestablished immediately. If the trust is lost, the therapeutic relationship is lost. In the initial steps of treatment, children with RAD are incapable of understanding relationship dynamics. This may be primarily due to their inconsistent relationship experiences. Perry claimed that “When a traumatized child is in a state of alarm (because they are thinking about the trauma, for example) they will be less capable of concentration, they will be more anxious and they will pay more attention to “nonverbal” cues such as tone of voice, body posture, and facial expressions. This has important implications for understanding the way the child is processing, learning, and reacting in a given situation” (Perry et al., 1995, p. 274). In order to protect the trust, the nurse may be forced to change their approach to rebuild the therapeutic relationship. This may include changing boundaries or rebuilding trust utilizing a different approach or
asking for assistance from a coworker. This may also include the complete reconfiguration of the therapeutic relationship.

The development of a therapeutic relationship requires reassurance, unconditional positive regard, empathy, and consistency. These are fundamental elements of the practice of nursing. The actual process of the relationship building falls within the responsibility of the nurse and treatment team. Pickle (2000), stated “Successfully treating a child with attachment disorder requires a coordinated team approach, enlisting the assistance of significant others and community systems” (Pickle, 2000, p. 261). We are taught that, as a nurse, these traits are essential to be able to care for patients in a nonjudgmental and compassionate way. These traits may occur both naturally and can be learned. It is important to acknowledge that the use of these traits is highly effective when working with children with behavioral problems. Gallop and Garfinkel (1990), stated in a discussion on empathy, “If nursing continues to espouse the value of empathy and therapeutic communication, then nurses must understand their roles in the interpersonal process so that they can understand how their behavior contributes to outcomes in nurse-patient dyad” (Gallop & Garfinkel, 1990, p. 16). These traits allow the child to feel supported and safe in their quest to build a therapeutic relationship with the nurse. If the nurse does not possess these qualities or is not able to portray them consistently, the therapeutic relationship suffers.

One limitation in this experiment was that three participants were from the same facility. This facility had the same policies and standards of care in place to follow. Conversely, they came from separate units of the hospital: the acute stay unit, children’s residential unit (ages 4-9), adolescent residential unit (ages 10-14), and adolescent
residential unit (ages 14-18). The participants held positions of management in addition to a staff position. The participants provided a point of view from varying age groups, experience, and understanding. Some subjects had a greater knowledge of RAD than others.

A second limitation was that these participants could not reveal any information about their patients that would identify them because of the policy of patient confidentiality. It was important to maintain the patients’ anonymity and not reveal anything that could easily identify them through stories or patient specific situations. Due to the participants’ only being able to share general information, it was not possible to gauge individual relationships on a high level. The focus was on relationships with children diagnosed with RAD. They were asked only to provide generalized information, making it more difficult to discern the effectiveness of the relationship built between the nurse and patient.

A third limitation found during the interview process was with the fourth interviewee. The participant came unprepared to the interview and did not directly answer the questions asked by the interviewer. The participant worked at a facility solely responsible for treatment of RAD but admitted to not acting in a key role on the treatment team and not interacting with the children unless a child was sick, and thus not forming relationships with the children. Due to the lack of experiences in relationship building this interviewee’s experiences were not used in the results of this thesis.

Reactive Attachment Disorder can be prevented if a child has a secure attachment. Additional data collection to support the notion that development of a therapeutic relationship with a child is a method of preventing RAD is necessary. Sved-Williams
(2003), stated, “The value of a secure base gained in infancy is evident in all aspects of life, and the potential to change parent–infant relationships rapidly can be seen clinically. Inpatient mental health (IMH) workers must master the challenge to show good outcome evidence that their interventions are effective” (Sved-Williams, 2003, p. 31). Prevention can begin at the time of infant care visits with nurses and health care providers asking questions such as “Do you feel like you have bonded with your baby?” and “How does your baby respond to you?” Prevention may also be done if a child is placed in an IMH institution through early therapeutic relationship building. Assessment and prevention may be more difficult in situations involving orphans, adoption, trauma, illness, traumatic loss of parents at a young age, or when lack of medical care is present. Pickle (2000) presents eight social strategies in her works on prevention of attachment problems. Places where prevention can occur are in community education programs, hospitals, day cares, the child welfare system, prenatal care, and community programs based on families and teen pregnancy (Pickle, 2000). Pickle continued “Early assessment and intervention are ways that the problem can be addressed before it grows and the child’s behavior becomes well entrenched” (Pickle, 200, p. 271). As nurses, we have a responsibility to assess for attachment problems in infants if we have the ability to do so. According to Ainsworth (1969), “Attachment refers to an affection tie that one person forms to another specific individual. Attachment is this discriminating and specific” (Ainsworth, 1969, p. 2). This tie may be essential to future attachments. More research has come out in the last decade but there is still a huge variance in evidence-based practice in the area of therapeutic relationship building and effectiveness.
An additional area of research, which is vital to the care and treatment of children with the diagnosis of RAD, is the need for increase in education of nurses to recognize and understand behaviors of RAD. There also is a need for standards of care to use within the treatment process of RAD. In contrast with disease process diagnosis and treatment, there are not specific treatment regimes in place for many behavioral health disorders, specifically Reactive Attachment Disorder. Rather than standards of care or care priorities, there are suggestions. Children diagnosed with RAD can present with many different etiologies and characteristics, which nurses need to be able to recognize acutely. Not every patient will present the same way, current diagnostic tools do not address the individuality of RAD. Presentation of RAD will be specific to whatever trauma the child has experienced. Perry (1995), an expert in behavior and the brain stated “Trauma is an experience. How is it that this experience can transform a child’s world into a terror-filled, confusing miasma that so dramatically alters the child’s trajectory into and throughout adult life? Ultimately, it is the human brain that processes and internalizes traumatic (and therapeutic) experience. It is the brain that mediates all emotional, cognitive, behavioral, social, and physiological functioning. It is the human brain from which the human mind arises and within that mind resided our humanity. Understanding the organization, function, and development of the human brain, and brain-mediated responses to threat, provides the keys to understanding the traumatized child”(Perry et al., 1995, p. 273). Too often nurses are not educated enough to understand the behaviors they see and be able to react in a way which is appropriate to them. Categorizing and generalizing behaviors to fit a scale is not an accurate way to assess for RAD. Garber (2004), argued, “Specifically, the present model will prove to be robust only to the extent
that attachment assessment instruments and attachment-based interventions prove to be practical, reliable, and valid in clinical and forensic settings. This calls for clinical and forensic professionals to rethink their models and to begin to integrate developmental theory into practice” (Garber, 2004, p. 66). There are diagnostic tools in place to aid in recognizing RAD yet little resources about how to interact with and treat those individuals.

One important piece of nursing care, which is often overlooked, is that of the health of the nurse. Every participant interviewed stated in some way that nurses working in the area of behavioral or mental health must be very careful about taking care of themselves and learning self-regulating measures. This includes knowing the scope of ones abilities and the amount that one can personally take on. Nurses must have coping mechanisms, which they can use to control their stress within and outside the workplace. One recurrent message from participants interviewed was the necessity of recognizing when to “tap out” or to allow themselves to be relieved by another staff member. Additional suggested future research would be an exploration of the dynamics involved when a nurse caregiver loses objectivity and believes that they are the only nurse who can help a particular child. This loss of objectivity may instead contribute to a disintegration of trust and a dysfunction in the nurse patient relationship.

Finally, the model constructed through the analysis of the interview process will not be applicable in every situation. Each theme really relates to the other. It is difficult to delineate and categorize because during the relationship it would be ideal to have each theme present at all times. There is not one way to form a relationship with a child with RAD. The model may not be able to be applied to every nurse patient interaction, but
rather is a starting point to raise awareness. Relationships are a key piece of the cause and the treatment of RAD. It is necessary that a comparison between the therapeutic relationship model of this study and current national guidelines related to inpatient pediatric nursing interventions be made. There is a great need for awareness and focus on RAD in studies on relationship building and relationship models. The more we learn about the formation and maintenance of a therapeutic relationship with children diagnosed with RAD the more we, as nurses, can provide individualized and effective care.
References


Appendices

1. Copy of informed consent.

2. The questions used in the interview process with participants

3. The Model “Insight into Developing a Therapeutic Relationship”
Appendix 1

Carroll College

Subject Consent Form

For Participation in Research Study

Project Title: Building Nursing Relationships with Individuals who have Reactive Attachment Disorder of Childhood

You are being asked to participate in a research study concerning the creation and fostering of healthy nursing relationships with children who suffer from Reactive Attachment Disorder of Childhood (RAD). This research is meant to examine the difficulties nurses overcome in working with children who have attachment problems and determining successful ways to create secure attachments. This study may aid in teaching other nurses a better understanding to the therapeutic relationship between a nurse and a patient with RAD. You must have worked in a psychiatric care facility for at least 2 years and have experience working with children who suffer from RAD. If you are interested in participating in this study you agree to share your insights in an audio taped interview for 30-60 minutes, which will later be transcribed. You will be asked to share your personal experiences with children with RAD, feelings about these situations, and your ideas on therapeutic communication and attachment disorders. If you agree to participate in this study all information gathered in the interview process will be kept confidential by using code numbers. There is no health risk associated with participation in this study.

I, ___________________________ (name), agree to participate in this research study outlined above. I understand that during the interview process no clients’ names or identifying information will be included and the confidentiality policy will be strictly followed. I am willing to dedicate 30-60 minutes to an audio taped interview. Elizabeth Phillips has thoroughly explained the nature and process of this research to me; if I have questions I can contact her with any questions at (425) 765-9824 or ephillips@carroll.edu. I understand that I have the right to withdraw from the study at anytime without explanation. I have been given a copy of this consent form to keep for my own records.

The best way to reach me to set up an interview is by: _____Phone

_____ Email

Phone number: ______________________________

Email: ______________________________


Appendix 2

Interview Questions

What do you think are key parts of developing a relationship with a patient?

Tell me about methods you have used to connect with your patients…

Tell me a little about your experience as a psychiatric nurse working with kids who have been diagnosed with RAD or who display traits of RAD…

Is there a specific case you remember? If so, tell me about it…

How did you go about forming a relationship with this patient?

What do you feel benefits patients with RAD in a treatment setting?

What do you feel interferes with treatment of children with RAD?

Could you tell me about your most successful attachment with a child who displayed traits of children with RAD or were diagnosed with RAD?

Did you do anything different in your attachment process with patients with RAD than with patients who did not have RAD or display traits of RAD?
INSIGHT INTO DEVELOPING A THERAPEUTIC RELATIONSHIP

Cycle can be repetitive even with the foundation of a successful relationship. It is cyclic rather than step-like. It reflects the formation of relationships with children with RAD.