

5-2016

# The Effectiveness of Play Therapy and Reactive Attachment Disorder: A Systematic Literature Review

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## Recommended Citation

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The Effectiveness of Play Therapy and Reactive Attachment Disorder:

A Systematic Literature Review

By

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Masters of Social Work Clinical Research Paper Proposal

Presented to the faculty of the School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota

In partial fulfillment of the requirements for the degree of Masters of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

## **Abstract**

The focus of this systematic literature review was to assess the effectiveness of play therapy used in treatment of children diagnosed with reactive attachment disorder (RAD). Children diagnosed with RAD experience long-term implications including inability to regulate emotions, difficulty building and maintaining relationships, behavioral issues, anxiety and poor autonomy. Play therapy is a therapeutic approach that eliminates barriers between the child and therapist. This review examined fourteen articles. The articles were found using inclusion criteria of including treatment of RAD, use of play therapy with RAD, published between 2000 and 2015 and used research with children age 0-18 years old. All articles were reviewed and articles that did not meet inclusion criteria were discarded. The full texts were reviewed and four themes were determined for effective treatment of RAD. These themes included strong family component, structured treatment, child-led treatment and a stable environment. These aspects of treatment proved to be effective in reducing symptoms of RAD.

## Acknowledgements

I would like to express sincere gratitude for my research chair, Ande Nesmith, Ph.D., for encouragement, dedication and for not allowing me to procrastinate. To my committee members, Melissa Tyo, LMFT and Jeanne Williamson, LICSW, your support, feedback, time and patience are greatly appreciated. I thank you for getting me to the end.

I would like to thank all my friends and family that cheered me on through these past two years. To my parents, Mike and Deb, your ongoing praise and encouragement are always so appreciated. Thank you for instilling in me the importance of education and loving what you do. To my thoughtful sister, Keli, my supportive brother-in-law, Peter, and spirited niece, Stella, thank you for your love and encouragement through these years. And finally, to my understanding boyfriend, Zach, I sincerely thank you for your patience and love during all my hours of class, homework, and stress. Your support means more than you know.

Cheers! To relaxation and time.

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## Background

Children diagnosed with reactive attachment disorder face a life of persistent social and emotional disturbances and significant impairment in the ability to form secure relationships throughout their life. Treating reactive attachment disorder can be difficult and it is important that clinicians are able to utilize effective interventions with the goal to improve the child's social and emotional functioning.

J. Bowlby, the father of Attachment Theory, started his research in 1956 to explore the responses of children with the loss of their mother. Then, Bowlby and colleague, James Robertson, began to analyze the reaction from children when they were separated and subsequently reunited with their mothers (Bowlby, 1982). The conclusion reached, was that the loss of the mother had a significant impact on the child's emotional wellbeing.

Attachment is defined as, "an affectional tie that one person or animal forms between himself and another specific one—a tie that binds them together in space and endures over time" (Ainsworth & Bell, 1970, p. 50). Humans are predisposed to form an attachment and build a secure bond with their primary caregiver. Attachment provides children with a secure base and allows for exploration out into the world (Main, 2000).

Children demonstrate their attachment type through attachment behaviors. Attachment behaviors are behaviors that encourage children to be in close physical contact with their caregiver; it is uncomfortable for children to be away from their caregiver (Ainsworth & Bell, 1970). Examples of these attachment behaviors are crying, sucking, cooing, smiling, and general interaction with the caregiver (Main, 2000). Bowlby

was able to look at attachment behaviors and organize criteria that led to categorizing different types of attachment. The criteria were based on the child's reaction when their mother left them and then the child's reaction when their mother returned (Bowlby, 1982). Main describes, the child's use of an attachment figure, typically the primary caregiver, as their only solution to resolve their distress (2000).

*The Strange Situation* was a research study conducted by Mary Ainsworth with the purpose of observing the degree to which a child uses their mother as a secure base for exploration in a strange environment (Ainsworth & Bell, 1970). Situations observed included: separating from the mother, reunifying with the mother and being introduced to a stranger. The behaviors of exploration, alarm and attachment were all observed (Ainsworth & Bell, 1970). Based on *The Strange Situation*, the child's behaviors could be organized into different styles of attachment including; secure, avoidant or resistant/ambivalent. Main describes in later work the addition of a fourth style of attachment: disorganized/disoriented (Main, 2000).

The attachment style a child forms is based on the organization of the relationship between the child and their primary caregiver (Ainsworth & Bell, 1970). Bowlby explains, the attachment style formed between the child and the primary caregiver is dependent on when and how the caregiver responds to the child's attachment behaviors (Bowlby, 1982). The attachment style is typically formed within the first year of the child's life.

Forming a secure attachment versus an insecure attachment reveals behaviors throughout the child's life. Secure attachments lead to healthy development through

the child's existence. Forming a secure attachment can improve the quality of life from the beginning. Kerns and Brumariu, 2014, claimed that children with secure attachments have positive expectations of others and strong autonomy. Children who initially form insecure attachments can be less likely to be successful both developmentally and emotionally. Insecure attachments can lead to behavioral issues, anxiety, internalizing behaviors, poor relationships, and inability to regulate emotions (Kerns & Brumarin, 2014).

The number of children who form an insecure attachment as their primary attachment is of significant concern given the implications that insecure attachments suggest throughout the child's lifetime.

According to an article written by B. Rose Huber, out of 14,000 U.S. children, 40% lack strong emotional bonds or secure attachments with their parental figures or caregivers. Of these 40%, 25% are determined avoidant and 15% of the children resist their parental figure because their parent causes them distress. Another article by Sean Brotherson, 2005, a Family Science Specialist at NDSU Extension Service, identifies that 55-65% of children form secure attachments and 35-45% form insecure attachments. These statistics show there is a significant number of children who are unable to form a secure attachment with their primary caregiver. Children who have formed a secure attachment can have an increase in positive relationships with peers, cooperation with adults and authority figures, and are better able to regulate emotions (Kerns & Brumarin, 2013).



## Reactive Attachment Disorder

All attachments fall on a spectrum. Children with the most acute symptoms of an insecure attachment are often diagnosed with reactive attachment disorder (RAD).

According to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), reactive attachment disorder is diagnosed in children with the most severe attachment problems. The DSM-5 identifies RAD as, “characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance,” (American Psychiatric Association, 2013 p. 265).

RAD is diagnosed based on criteria determined when there is an attachment between caregiver and child that is nonexistent or markedly underdeveloped (American Psychiatric Association, 2013). Identifying criteria includes: consistent patterns of inhibited and emotionally withdrawn behavior towards caregiver, persistent social and emotional disturbances, patterns of extremes in insufficient care, repeated changes in primary caregiver and clinician is able to rule out all other disorders. The diagnosis can only be made when a child is younger than the age of five and has a developmental age of above nine months (American Psychiatric Association, 2013). The DSM-5 identifies, “Reactive attachment disorder significantly impairs young children’s abilities to relate interpersonally to adults or peers and is associated with functional impairment across many domains of early childhood” (American Psychiatric Association, 2013, p. 267).

## Play Therapy

Child psychotherapy can be a hard task to accomplish for any clinician/therapist. Children think and behave differently than adults, therefore, therapeutic approaches that are successful with adults need to be revamped for therapeutic work with children. Many children need support with emotional literacy. According to Play Therapy International, 71% of children referred to play therapy will show a positive change (2008).

Play therapy is an approach that has tailored traditional psychotherapy to accommodate the child's brain. It symbolically disguises itself in a child's natural way of communication; play (Webb, 2007). Play therapy is a strategy utilized with children due to play being a child's natural expression (Cooper & Lesser, 2011). Several different approaches can be utilized including: using objects metaphorically, reinforcing or extinguishing behaviors, modeling behaviors, adapting behaviors, directions by the therapist or relying on the child's direction of play (Cooper & Lesser, 2011). Play therapy allows for clinicians to work with children despite their developmental stage or cognitive functioning. This approach can also be used to gain knowledge and understanding when there may be cultural barriers or language barriers between the child and the clinician. Children will rarely admit to have any behavioral problems or difficulties at home when their family may be at their wits end about it. Working with a play therapist can allow for these issues to be addressed without the child becoming defensive (Webb, 2007). Finally, the ability to use play to express themselves allows children to experience reduced stress that might otherwise have been a barrier if the child is expected to

communicate verbally. Cooper & Lesser, 2011, describe that play can be a valuable way to gather information related to the child's internal conflict.

The long-term implications of children diagnosed with reactive attachment disorder along with the effective use of play therapy eliminating barriers in the child-clinician relationship is the reason for more research to be done on the effectiveness of play therapy with children diagnosed with reactive attachment disorder.

### **Conceptual Framework**

The focus of this systematic literature review is to assess the effectiveness of play therapy used in treatment of children diagnosed with RAD. With the goal to help social workers identify clinical approaches that will improve the functioning of children diagnosed with RAD. The main theory identified as guiding the research presented is Attachment Theory. Attachment theory focuses on the initial attachment formed with a primary caregiver and the impact this relationship has on the child's development, response to anxiety and security in attachments (Teyber & McClure, 2011). Infant's primary instinct is to establish a secure emotional attachment to their primary caregiver. The argument is made that this primary attachment shapes the child's subsequent relationships. Teyber & McClure (2011) explain, when parents are able to accurately respond to their child's emotional needs the child is able to form a secure attachment. However, when the parent does not adequately respond to their child's emotional needs the child forms an insecure attachment.

To further categorize these attachment styles, there are two organized attachments identified and one disorganized attachment that all fall under the umbrella

of insecure attachments. The organized attachments include avoidant and ambivalent (Teyber & McClure, 2011). Avoidant attachment is formed when the child becomes conditioned to the primary caregiver consistently ignoring, dismissing and rejecting the child's needs. The caregiver of a child with an avoidant-insecure attachment is unresponsive (Teyber & McClure, 2011). Ambivalent attachment is formed when the caregiver is intrusive, responds inconsistently, and demonstrates difficulty supporting the child's independence. Disorganized attachment is developed when the attachment pattern is unpredictable and demonstrates no organization. Without strong characteristics of any attachment pattern, the child has often experienced or experiences trauma, abuse, neglect or dissociative behavior from their parents (Teyber & McClure, 2011). Children who are identified as having a disorganized attachment have difficulty sustaining consistent relationships and are at high-risk for more serious mental health issues throughout their life.

## **Methods**

A systematic literature review is research and evaluation of literature that currently exists on a specific topic. A systematic review was used to bridge a gap in the current research and use knowledge and language previously defined to analyze a specific topic. Using this research method, a collection of the most applicable research done addressing the effectiveness of play therapy used with children diagnosed with Reactive Attachment Disorder was assessed. The research was found using specific inclusion criteria and data analysis methods.

### Inclusion Criteria

The topics of the articles that meet criteria focus on reactive attachment disorder or play therapy. All articles included research on RAD however, not all articles included play therapy as the intervention. Research that was reviewed included treatment approaches for children diagnosed with RAD, published between 2000 and 2015 and included research based on children ages 0-18 years old. The abstracts were reviewed to determine if the source was applicable and articles that were discarded are further explained in the finding sections of this review.

Empirical research was used to identify effectiveness of play therapy when treating RAD. Empirical research can be defined as research derived from experience rather than theory and is based on observation and measurement of a situation (Amsberry, 2008). Articles that use other therapeutic interventions besides play therapy were considered for inclusion when the research was on children diagnosed with RAD. All studies included address the treatment of children diagnosed with RAD. Any studies that did not include children diagnosed with RAD were excluded.

### Search Strategy

Sources were established using databases found through University of St. Thomas library and included Ebscohost, socINDEX, and Social Work Abstracts. The key words used to search included: play therapy, reactive attachment disorder, attachment disorder, attachment disruption, attachment therapy, play therapy techniques, attachment based interventions, evidence based interventions to address attachment,

and treatment for RAD. Any articles that did not include identified topics were discarded.

### Data Analysis

The analysis of data included tracking the articles found during each key word search and the number sources excluded due to identified inclusion criteria. The sources included are rated on a scale of one to three. Three different characteristics; sample size, sampling strategy and longitudinal study were rated. The findings will report scores. The scores for articles individually have the three different characteristics added together. An average score will be reported in regards to each theme. The following table describes the rationale for each rating.

**Data Abstraction Table**

| Method            | Quality                 |              |           |
|-------------------|-------------------------|--------------|-----------|
|                   | 1 (poor)                | 2 (moderate) | 3 (high)  |
| Sample size       | <5                      | 6-15         | >16       |
| Sampling strategy | Convenience or snowball | Matched      | Random    |
| Longitudinal      | Cross sectional         | < 6 months   | >6 months |

Sample size was determined based on the low prevalence of diagnosed RAD as determined by the DSM-5 criteria. According to the DSM-5 the prevalence of RAD is unknown but is identified as seen rarely by clinicians. In populations of severely neglected children the disorder occurs in less than 10% of children (DSM-5, 2013).

Sampling strategy was reviewed and scored. Random sample was the highest quality as random samples are the most unbiased sample. Matched design was determined to be moderate quality due to RAD being rarely diagnosed in children, therefore, picking a sample diagnosed with RAD will narrow down the sample size as a whole. A longitudinal study was determined to be the most valuable use of measurement due to the research question including the effectiveness of play therapy as a treatment and the results of effectiveness is only able to be studied over time.

The sources included in the research were recorded in an excel spreadsheet to ensure accurate organization. After each search using the search topics and key words, the number of sources found was recorded. The abstracts were reviewed first to ensure the inclusion criterion was met. If so, the methods and findings were reviewed and organized into the Analysis Table. The Analysis Table is organized using the headings: author/date, design, sample size/groups, measures, and quality score obtained from the Data Abstraction Table previously described. The sources with the highest sum quality score were then filtered down and the number was recorded. All sources were reviewed and filtered to determine the most applicable sources. Any sources that were excluded will be explained in the Data Collection Table on page 14.

## **Findings**

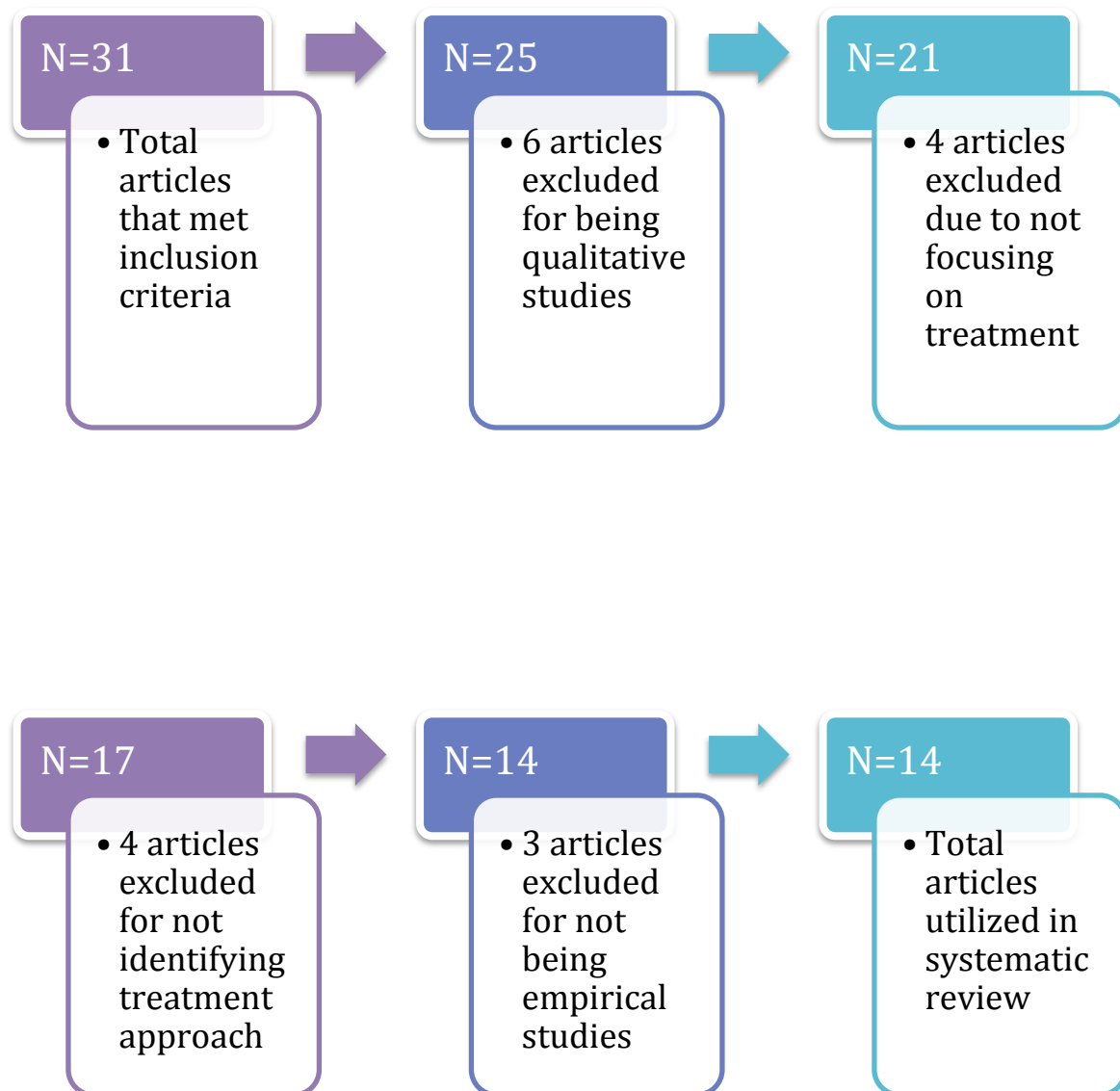
The goal of this systematic literature review was to examine and review research previously done to address the effectiveness of play therapy with children diagnosed with RAD. The articles used in this systematic review were obtained from electronic databases including Ebscohost, socINDEX and Social Work Abstracts. Search terms used

included: reactive attachment disorder, play therapy, attachment based interventions and treatment for reactive attachment disorder. When reviewing the findings for these searches, 31 articles met inclusion criteria and were set aside for further review. Upon further review of the 31 articles, six of these articles were qualitative research and were discarded. Four articles were discarded due to studying the type of attachment children presented with during treatment process and did not focus on the effectiveness of treatment for children with RAD. Four more articles were discarded due to not identifying any specific treatment approach and the last three articles were discarded due to not being empirical studies. See the data collection table for further review.

Fourteen articles were identified as applicable due to meeting the inclusion criteria described in the Methods section of this paper. The fourteen articles were further reviewed and analyzed for the purpose of this systematic review. Common themes included a strong family component in the treatment approach, structured treatment, child-lead treatment and a stable home environment before treatment can be successful. Multiple studies are included in one or more themes and some in all four. The Data Analysis Tables outline the fourteen articles, their sum quality score, and are organized by theme.



### Data Collection Table



### Theme Comparison

All fourteen articles focused on the aspects of treatment that are effective for children diagnosed with RAD. The characteristics of each treatment approach are more

relevant than the specific type of therapy being used. Therefore, the characteristics of the treatment approach will be the focus rather than a specific type of therapy. There are four themes that the research identified as important characteristics for effective treatment working with children diagnosed with RAD: strong family component, structured treatment, child-led treatment and stable environment.

### **Strong Family Component**

The first theme identified is a strong family component in the child's treatment. Having the caregiver involved in treatment allows for a secure attachment to be built with the caregiver. The caregiver will provide a secure base for that child. "Caregiver involvement in the treatment process, providing that caregiver is psychologically healthy enough to participate appropriately, is believed to be an important contributor to positive treatment outcomes" (Hardy, 2007, p. 33).

Nine of the fourteen articles identified a strong family component in treatment is an aspect that indicates effective treatment for children diagnosed with RAD. The overall average quality score for the all articles with a strong family component as a theme is 6.8. Making these articles above average quality of research. The idea of a strong family component is for the child to have a secure base to build a secure attachment to their caregiver or caregivers. Shi (2104) reports that the essence of attachment therapy is the establishment of a safe haven and a secure base for that child. The most significant aspect of therapy focusing on attachment is to rebuild the human connection (Shi, 2014). In order for the child to be functioning in social and familial settings and reduce symptoms of RAD, the child must amend the insecure

attachment they formed earlier in life. Becker-Weidman (2006), with an overall quality score of 8, identified that involving the family in treatment allowed for the formation of a secure base to explore past trauma. Dyadic developmental psychotherapy was used “... as a way of creating a safe and secure base from which the child can explore past trauma” (Becker-Weidman, 2006, p. 159-160). Furthermore, behavioral changes will not be seen until the child is able to form a secure attachment (Wimmer, Vonk, & Bordnick, 2009). Research supports that when working with a child diagnosed with RAD the first goal is to form a secure attachment for the child to have a safe haven and secure base to work through the remaining issues. “The clinical decision to work first on human connection rather than behavioral intervention was based on the critical understanding that secure attachment is the precursor for any desired behavioral changes” (Shi, 2014, p. 11). Taylor reported that once the treatment focused on the family as a system instead of an “identified patient,” being the child, the treatment proved to be effective (Taylor, 2002). This specific study used Eye Movement Desensitization and Reprocessing (EMDR) as the treatment approach. As the child felt a positive increase in their missing developmental stages the social and family behaviors improved (Taylor, 2002). Henley, with an overall quality score of 7, utilized the treatment approach of art therapy that also included an active parent component and saw a decrease in RAD symptoms because of the improvement in relationship between mother and child (Henley, 2005). Weir studied the use of Theraplay when working with children diagnosed with RAD. Theraplay approach “suggests that healthy attachments are formed when a balance of structure, engagement, nurture, and challenge dimensions are fostered in a relationship

through the therapeutic context of playfulness” (Weir, 2007, p. 5). Theraplay directly addresses the relational strains that a RAD diagnosis indicates and assists attachment in the family system (Weir, 2007). “The model requires and assists parental (or caregiver) participation that is healthy as a contrast to the pathogenic care a child received from their abusive or neglectful caregivers as part of their early history” (Weir, 2007, p. 12). The use of Theraplay proved to be an effective treatment of RAD due to the consistent participation with the child’s caregivers for the ability to reconstruct a secure attachment. Dozier et al., with an overall quality score of 7, used clinical professionals to train parents in order for parents to provide the therapeutic environment and be able to form a secure attachment with their child rather than the therapist providing the environment. Therefore, the child would form an attachment with the parent and not the therapist, this approach proved effective in reducing symptoms of RAD because it focused on the attachment between child and parent (Dozier et al., 2009). Inclusive research supports a strong family component in treatment, for the purpose of rebuilding the attachment, is effective in reducing symptoms of RAD.

**Table 1: Strong Family Component Data Analysis**

| Author/ Date                                 | Sample Size (score) | Method (Score) | Design (score) | Total Quality Score |
|--|---------------------|----------------|----------------|---------------------|
| Wimmer, J., Vonk, M., & Bordnick, P. (2009). | N=24<br>3           | Matched<br>2   | >6 mo.<br>3    | 8                   |
| Taylor, R. (2002).                           | N=1<br>1            | Matched<br>2   | >6 mo<br>3     | 6                   |
| Shi, L. (2014).                              | N=1<br>1            | Matched<br>2   | <6 mo<br>2     | 5                   |
| Weir, K. N. (2007).                          | N=1                 | Matched<br>2   | >6 mo<br>3     | 6                   |
| Becker-Weidman, A. (2006).                   | N=64<br>3           | Matched<br>2   | >6 mo<br>3     | 8                   |

|  |           |              |            |   |
|--|-----------|--------------|------------|---|
| Hardy, L. T. (2007).   | N=1<br>1  | Matched<br>2 | >6 mo<br>3 | 7 |
| Scott Heller, S., Boris, N. W., Fuselier, S., Page, T., Koren-Karie, N., & Miron, D. (2006). | N=2<br>1  | Matched<br>2 | >6 mo<br>3 | 6 |
| Henley, D. (2005, January).  | N=11<br>3 | Matched<br>2 | >6 mo<br>3 | 8 |
| Dozier, M., Lindhiem, O., Lewis, E., Bick, J., Bernard, K., & Peloso, E. (2009, February).   | N=46<br>3 | Matched<br>2 | <6mo<br>2  | 7 |

### Structured Treatment

Structured treatment was included in eleven of the fourteen research articles. The average quality score for said eleven articles is seven. Seven is an above average quality score for research based on the *Data Abstraction Table*, meaning, the research supporting structured treatment approach when working with children diagnosed with RAD is satisfactory research.

The use of structure in the therapeutic approach provides the child with consistency and predictability. Similar the strong family component theme, this theme focuses on the child having a stable environment both in therapy and at home. In order to decrease the symptoms of RAD. According to Hardy, a study with a quality score of 7, in children with RAD and drastically maladaptive attachment patterns, more directive therapeutic approaches are required (2007). The experience of the child knowing what to expect each time they come to therapy allows for the stability to calm their mind. Children with RAD tend to live in a persistent state of fear, have a dysregulated affect and avoid intimacy (Taylor, 2002). Having a methodical and predictable therapy process provides a framework to hold their emotions while they sort through them. Shi, with a quality score of 5, finds that having reasonable rules and structure to therapy sessions plays an important role in helping the child feel safe (2014). “Despite the chaotic session

the therapist still believed it was important to apply the structure that had been established because it was a predictable routine and a structure he had grown comfortable with” (Shi, 2014, p. 7-8).

Structure is vital to children with RAD because of the internal chaos they experience relentlessly. Structured treatment can provide the only order in their disoriented mind. Becker-Weidman, with an overall quality score of 8, reports, “effective parenting methods for children with trauma-attachment disorders require a high degree of structure and consistency, along with an affective milieu that demonstrates playfulness, love, acceptance, curiosity and empathy” (2006, p. 159). Predictability is key to effective treatment for RAD. Weir uses a combination of Structural Family Therapy and Theraplay with specific methodology for each therapy session to ensure the child is able to predict the therapeutic space in which they will work through their attachment disorder (2007). The family has specific roles during the therapy sessions and homework to continue to bridge the structure of therapy into the home. The crucial quality to successful treatment is structure (Weir, 2007). Becker-Weidman utilized Dyadic Developmental Psychotherapy when working with children diagnosed with RAD, a therapeutic approach that consists of intense structure and predictability. He stressed the importance of the structure not being contained to the therapy sessions but must be transmitted into the home through parenting techniques. “Effective parenting methods for children with trauma-attachment disorders require a high degree of structure” (Becker-Weidman, 2006, p. 159). Because of this, Becker-Weidman chose to teach the parent methods that focus on non-verbal interaction to

address the negative internal working models that co-exist with RAD (2006). This approach ensures structure provided by the therapist and the caregivers. “The caregivers provide a high degree of structure to provide safety for the child” (Becker-Weidman, 2006, p. 159). Research provides an outline for the therapeutic process to include consistent structure in order to effectively treat RAD.

**Table 2: Structured Treatment Data Analysis**

| Author/ Date   | Sample Size (score) | Method (Score) | Design (score) | Total Quality Score |
|--|---------------------|----------------|----------------|---------------------|
| Wimmer, J., Vonk, M., & Bordnick, P. (2009).   | N=24<br>3           | Matched<br>2   | >6 mo<br>3     | 8                   |
| Taylor, R. (2002).   | N=1<br>1            | Matched<br>2   | >6 mo<br>3     | 6                   |
| Shi, L. (2014).  | N=1<br>1            | Matched<br>2   | <6 mo<br>2     | 5                   |
| Weir, K. N. (2007).  | N=1<br>1            | Matched<br>2   | >6 mo<br>3     | 6                   |
| Becker-Weidman, A. (2006).   | N=64<br>3           | Matched<br>2   | >6 mo<br>3     | 8                   |
| Hardy, L. T. (2007).   | N=1<br>1            | Matched<br>2   | >6 mo<br>3     | 7                   |
| Sheperis, C. J., Renfro-Michel, E. L., & Doggett, R. A. (2003, January).                   | N=1<br>1            | Matched<br>2   | >6mo<br>3      | 6                   |
| Henley, D. (2005, January).  | N=11<br>3           | Matched<br>2   | >6 mo<br>3     | 8                   |
| Dozier, M., Lindhiem, O., Lewis, E., Bick, J., Bernard, K., & Peloso, E. (2009, Febraury). | N=46<br>3           | Matched<br>2   | <6mo<br>2      | 7                   |
| Philip, F., & Hyoun, K. (2007).  | N=117<br>3          | Matched<br>2   | >6mo<br>3      | 8                   |
| Hoffman, K.T., Marvin, R.S., Cooper, G., & Powell, B. (2006, December).                    | N=65<br>3           | Matched<br>2   | >6mo<br>3      | 8                   |

### Child-Led Treatment

Child-led treatment focuses on children expressing themselves and dealing with their trauma in a way that is most comfortable to them. Five of the fourteen articles provide research to support a child-led treatment approach that is effective in treating RAD. The overall quality score of child-led treatment theme is seven. The overall quality

score of seven evidences the research is applicable to effective treatment processes.

Henley, with an overall quality score of eight, uses art therapy as an approach where the child is given the ability to lead the therapeutic process by way of art and is proven to be effective in reducing the symptoms of RAD. "Treatment strategies for reactive attachment disorder are often non-conventional and even controversial, reflecting the condition's severity and intractability" (Henley, 2005). Non-traditional treatment includes allowing the child to lead therapy and is effective because of the severity of RAD symptoms. Often, symptoms of RAD include lack of self-control and the diagnosis of RAD implies maltreated or traumatic treatment at an early age, which was not in the child's control. For these reasons, allowing the child to have some control in their treatment provides them with a newfound sense of self-effectiveness (Sheperis, Renfro-Michel, and Doggett, 2003). Due to the trauma the child experienced, that warranted them the diagnosis of RAD, typically occurring at a young, pre-verbal, age allowing the child to lead the treatment to express and work through this trauma in whatever, non-traditional, format works for the child is most effective. It is effective because the trauma took place at a pre-verbal age and a child typically articulates their trauma through play, a non-verbal use of communication. If the child is not allowed to direct therapy utilizing their play, they will be unable to reduce their symptoms of RAD (Becker-Weidman, 2006). Shi argues that a child with RAD often exhibits dangerous behaviors because they are unable to use words to describe the chaos within their mind (2014). It is because of this that the significance of child-led treatment is emphasized. Children with RAD often refuse to respond when talked to or talked at but have been



said to interact with therapeutic play. Shi reports the entire treatment process consists of “moments after moments of assessments and responses” (2014, p. 11) to the child that begin to change the child’s state of mind. If the therapist is unwilling to do this moment-by-moment child-led treatment, the child’s mind will not be able to create order and the security of attachment, which lead to effective treatment of the RAD symptoms. Therapeutic approaches grounded in attachment theory allow for the child to express as they see fit as a base in which the rebuilding of their attachment style can occur (Wimmer, Vonk, & Bordnick). Child-led treatment is proven to provide effective outcomes when working with children diagnosed with RAD.

**Table 3: Child-Led Treatment Data Analysis**

| Author/ Date   | Sample Size (score) | Method (Score) | Design (score) | Total Quality Score |
|--|---------------------|----------------|----------------|---------------------|
| Wimmer, J., Vonk, M., & Bordnick, P. (2009).                             | N=24<br>3           | Matched<br>2   | >6 mo.<br>3    | 8                   |
| Shi, L. (2014).  | N=1<br>1            | Matched<br>2   | <6 mo<br>2     | 5                   |
| Becker-Weidman, A. (2006).   | N=64<br>3           | Matched<br>2   | >6 mo<br>3     | 8                   |
| Sheperis, C. J., Renfro-Michel, E. L., & Doggett, R. A. (2003, January). | N=1<br>1            | Matched<br>2   | >6mo<br>3      | 6                   |
| Henley, D. (2005, January).  | N=11<br>3           | Matched<br>2   | >6 mo<br>3     | 8                   |

### Stable Environment

Twelve out of the fourteen articles proved a stable environment is necessary for the treatment of children with RAD. The average quality score for research on a stable environment being a vital part of treatment is 7.2. This quality score shows that the research is pertinent research. Research shows that before a child can explore their trauma they need a stable environment to do so within. Similar to the stability described

with a strong family component, a stable environment is necessary for effective treatment of RAD. Within an attachment centered, stable environment, a child is able to allow themselves to feel the love in forming a secure attachment with their caregiver (Shi, 2014). The effective application of treatment is able to occur within a stable living environment. Shi (2014) describes that a stable environment provides a ground for a child to “nurture their roots and start to grow into a secure attachment” (2014). Furthermore, a child is likely to be re-traumatized and become more distrustful if a secure environment is offered and then removed. If the environment is unpredictable the child may also be re-traumatized (Shi, 2014). The unstable nature of RAD needs a stable environment to reduce the symptoms. Weir researches the effectiveness of treatment of RAD once a child has been adopted (2007). Thus, the child is in a stable environment of the adoptive family. According to Becker-Weidman, attachment-based parenting is intertwined with a stable environment (2006). Hardy explains that the therapeutic environment is the most consistent precursor for effective treatment (2007). Since treatment for attachment disorders is based on attachment theory, stable environment is deeply embedded into any treatment of attachment related disorders, including RAD. Consequently, the research also shows treatment of attachment related disorders in children not in stable environment proves to be ineffective because of the arbitrary and impulsive environment (Hardy, 2007). Beneficial treatments of RAD should include a secure and nurturing environment (Sheperis, Renfro-Michel, & Doggett, 2003). Because of this, Sheperis, Renfro-Michel, and Doggett researched the effectiveness of in-home therapy building on the idea of a stable environment allows for

effective treatment (2003). Smyke, Zeahan, Gleason, Drury, Fox, Neson, & Guthrie argue that no treatment approach will be successful with RAD until the child is in a stable environment (2012). It is difficult to separate the stable caregiver involvement and stable environment, as these two appear to go hand in hand within the research. Both allow for the child to stay true to attachment theory and need a secure base (attachment figures and environment) to return to in order to successfully explore the world around them. When the child is able to feel the effects of having a secure base he or she is able to form a secure attachment thus reducing the symptoms of RAD and proving to be an effective aspect of treatment. The child will use the secure attachment to explore the unknown.

**Table 4: Stable Environment Data Analysis**

| Author/ Date   | Sample Size (score) | Method (Score) | Design (score) | Total Quality Score |
|--|---------------------|----------------|----------------|---------------------|
| Shi, L. (2014).  | N=1<br>1            | Matched<br>2   | <6 mo<br>2     | 5                   |
| Weir, K. N. (2007).  | N=1<br>1            | Matched<br>2   | >6 mo<br>3     | 6                   |
| Becker-Weidman, A. (2006).   | N=64<br>3           | Matched<br>2   | >6 mo<br>3     | 8                   |
| Hardy, L. T. (2007).   | N=1<br>1            | Matched<br>2   | >6 mo<br>3     | 7                   |
| Scott Heller, S., Boris, N. W., Fuselier, S., Page, T., Koren-Karie, N., & Miron, D. (2006). | N=2<br>1            | Matched<br>2   | >6 mo<br>3     | 6                   |
| Sheperis, C. J., Renfro-Michel, E. L., & Doggett, R. A. (2003, January).                     | N=1<br>1            | Matched<br>2   | >6mo<br>3      | 6                   |
| Smyke, A.T., et. Al (2012, May).   | N=208<br>3          | Random<br>3    | >6 mo<br>3     | 9                   |
| Henley, D. (2005, January).  | N=11<br>3           | Matched<br>2   | >6 mo<br>3     | 8                   |
| Cappelletty, G. G., Brown, M. M., & Shumate, S. E. (2005).                                   | N=54<br>3           | Matched<br>2   | >6 mo<br>3     | 8                   |
| Dozier, M., Lindhiem, O., Lewis, E., Bick, J., Bernard, K., & Peloso, E. (2009, Febraury).   | N=46<br>3           | Matched<br>2   | <6mo<br>2      | 7                   |
| Philip, F., & Hyoun, K. (2007).  | N=117<br>3          | Matched<br>2   | >6mo<br>3      | 8                   |

|   |           |              |           |   |
|---|-----------|--------------|-----------|---|
| Hoffman, K.T., Marvin, R.S., Cooper, G., & Powell, B. (2006, December). | N=65<br>3 | Matched<br>2 | >6mo<br>3 | 8 |
|---|-----------|--------------|-----------|---|

### Play Therapy Treatment

Four articles utilized play therapy as the treatment approach for children diagnosed with RAD. The use of play is used as a treatment approach due to the non-verbal nature of play. Play is a child's natural impulse. Play is meeting the child where they are at in terms of communication and allowing for the child to utilize what is normal to them in order to contain the chaos of a RAD mind. Treatment utilizing play therapy brings the joy and fun of play to contrast the strain often found in the relationship between the child and caregiver and the pain and trauma typically experienced in previous attachment when the child is diagnosed with RAD (Weir, 2007). When the play is geared to the developmentally appropriate age of the child, the children will feel safe enough to use play to express themselves (Weir, 2007). Becker-Weidman reports that a playful, loving, and accepting therapeutic environment is the basis for effectively treating RAD (2006). "Treatment of the child has a significant non-verbal dimension since much of the trauma took place at a pre-verbal stage and is often dissociated from explicit memory" (Becker-Weidman, 2006, p. 160). The non-verbal treatment often involves play, as this is the child's natural way of communicating. Children with RAD often have not had the role modeling of expressing emotions effectively as their attachment is so disorganized. Therefore, they cannot put into words their emotions. Play allows for their emotions to be conveyed. Processing the trauma through play therapy allows for the treatment to continue despite the child's lack of ability to communicate.

### Strengths and Limitations

There are both strengths and limitations to RAD research and play therapy. One significant limitation included the small frequency of children diagnosed with RAD according to the DSM-5. This limited the amount of research studies conducted along with the size of the sample utilized in each of the research studies. Another limitation of the research stems from play therapy being a more recent intervention used with children. This resulted in a lack of research including longitudinal studies and the effectiveness of play therapy working with children diagnosed with RAD. Lastly, another limitation of the research included the sample size being matched due to the research exploring effective treatment for children diagnosed with RAD. Therefore, the research had to select children that were diagnosed with RAD and eliminated the possibility of a random sampling type.

Strengths in the research included attachment theory being the focus of extensive research that has been conducted and documented for over fifty years. Another strength to this review included the increased frequency of play therapy used by clinicians working with children in recent years leading to increased research done on the effectiveness of play therapy more recently. Finally, a strength includes play therapy being an evidenced based approach indicating applicable research in regards to play therapy as a treatment approach.

### Discussion

This systematic review examined the effectiveness of play therapy when working with children diagnosed with RAD. Fourteen articles were reviewed and four themes

were identified and discussed. The purpose was to examine current literature to determine effective treatment for RAD. Although there is minimal research specifically utilizing play therapy as the treatment approach (four of the fourteen articles) many of the elements of play therapy are discussed in all other treatment approaches. There were four main themes that proved to be effective in the treatment of RAD. These included a strong family component in the treatment process, a structured treatment approach, child-led treatment and the need for a stable environment. All proved to be vital pieces in effectively treating symptoms of RAD.

Results of this review suggest that a specific treatment approach has not yet been identified as the one effective treatment for RAD. However, the research brought forth specific elements of the treatment process that prove to be effective. The findings advise that in order for a child to show progress in symptoms of RAD they must form a secure base and a secure attachment in which the child will utilize as scaffolding to create order in the chaos of their mind. While several studies (ten of the fourteen) did not utilize play therapy specifically, all fourteen studies found the importance of forming a secure attachment as effective treatment for RAD.

All fourteen articles utilized treatment that was effective in reducing symptoms of RAD. This aspect proves that it is more important to incorporate the elements of effective treatment: strong family component, structured treatment, child-led treatment and a stable environment. Using these elements replace the need for a specific therapeutic approach in the treatment of RAD. For example, EMDR, Dyadic Developmental Psychotherapy, art therapy and Theraplay all attested to be effective

treatment for RAD. Nevertheless, all fourteen studies discussed the limitation of not enough research being done for treatment of RAD or any attachment disruptions.

Fourteen of the studies were longitudinal studies as this is pertinent to measure the effectiveness of treatment. Of these fourteen, twelve studies were researched for more than six months. However, it is unclear the length of time specifically proven to see a reduction in behaviors. As predicted, all fourteen studies discussed the uncertainty of length that is effective in treatment as each child's process will be different. The overall theme of the research included the importance of implementing treatment including a strong family component, structure, child-led treatment, and a stable environment. These qualities of treatment are what substantiate the effectiveness of treatment when working with children diagnosed with RAD.

### **Implications for Social Work Practice**

It is important for clinicians to continue to develop knowledge and understanding to effectively treat RAD due to the severity and brutality the disorder brings. The purpose of this review was to determine effective elements in treatment to reduce symptoms of RAD. Clinicians should understand the difficulty that developing an insecure attachment brings on the child and the life long implications that impact the child. Once the child is in a stable environment with supportive caregivers the child is able to build a secure attachment and improve their functioning in social and familial environments.

Treatment is most beneficial when it includes a strong family component, structure, child-led activities and a stable environment to implement the treatment

within. Based on research, clinicians should incorporate these techniques when working with children diagnosed with RAD. However, there is an inconclusive amount of research to determine specific therapeutic approaches. Much more research will need to be conducted to further the understanding of treating children diagnosed with RAD.

### **Implications for Research**

While the results were all favorable to techniques effective in treating RAD, there are many further research opportunities. There is a significant opportunity to research the effectiveness of play therapy when working with children diagnosed with reactive attachment disorder. It will be beneficial to identify a specific therapy approach or approaches that can be utilized when working with the child and their family when the child is diagnosed with RAD.

Due to the specific research question of identifying if play therapy was effective in working with children diagnosed with RAD, it would prove beneficial to research the effectiveness of play therapy. Focusing on the effectiveness of play therapy will determine if the use of play therapy would be beneficial in reducing RAD symptoms. Further research in the area of play therapy and its effectiveness will provide clinicians with a framework for training and implementation of the treatment approach.

The goal of this systematic review was determining the effectiveness of play therapy working with children diagnosed with RAD. Within the fourteen articles analyzed, there are four elements of treatment that present as effective. These elements include a strong family component to treatment, structured treatment, child-led treatment and for the child to be living in a stable environment. Said aspects of the



therapeutic process prove to be effective in treating RAD. There is a significant indication that more research is needed to prove the effective treatment approach for treatment of children diagnosed with RAD. Further research will provide clinical social workers with a framework for improving the quality of life for children and their families affected by RAD. While results of this systematic review found effective treatment, there continues to be an ambiguous amount of knowledge that can be applied when working with these families. For more detailed and specific therapeutic approaches, more research should be conducted to determine definite methodology when treating children diagnosed with RAD. When that methodology is further developed it can be allocated to the clinical social work community.

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