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Reactive attachment disorder

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Abstract
Reactive Attachment Disorder, or RAD, has several possible causes usually stemming from traumatic childhood events. The attachment disorders were initially explored in 1948 by John Bowlby which led to the attachment theory being established in the 1960's. Attachment is the bond a child makes with other human beings, allowing for a healthy emotional and psychological growth. Attachment is developed primarily from birth to two years of age and up to the age of five.

There are four attachment styles and four phases that a child must go through to develop a healthy attachment to a caregiver. A child who is cheated out of this element of development can develop RAD. The lack of attachment established within in the first five years of life can lead to unhealthy, even unlawful events or violent, unhealthy interactions and relationships with others.

REACTIVE ATTACHMENT DISORDER

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Abstract

Reactive Attachment Disorder, or RAD, has several possible causes usually stemming from traumatic childhood events. The difference of the prevalence of RAD varies from source to source. The attachment disorders were initially explored in 1948 by John Bowlby which led to the attachment theory being established in the 1960's. Attachment is the bond a child makes with other human beings, allowing for a healthy emotional and psychological growth. Attachment is developed primarily from birth to two years of age and up to the age of five. There are four attachment styles and four phases that a child must go through to develop a healthy attachment to a caregiver. A child who is cheated out of this element of development can develop RAD. The lack of attachment established within in the first five years of life can lead to unhealthy, even unlawful events or violent, unhealthy interactions and relationships with others.

Reactive Attachment Disorder

Attachment disorders were first explored by John Bowlby, who researched attachment due to his heightened interest after observing hospitalized and institutionalized children who were separated from their parents. That was in 1948, and the attachment theory was developed in the 1960's. Bowlby reported his conceptualization of attachment as "a biological drive towards species survival," cited in Wilson, 2001.

Reactive attachment disorder, or RAD has been explained as a complex childhood psychiatric illness that begins in infancy or early childhood. There is no specifically known cause, however, the perceived cause is due to the disruption in the attachment cycle between the infant and his or her primary caregiver. Children diagnosed with RAD experienced multiple and possible indifferent caregivers within the first year of life. It is common for a child diagnosed with RAD have experienced emotional, sexual, or physical abuse. There is the possibility the child may have received inadequate care while in an institutional setting, including an orphanage, residential treatment facility, hospital, or a foster home. Sheperis, Renfro-Michael & Doggett (2003) reported when the trauma precedes a child's placement in the foster care system, it leads to lasting mental health difficulties. However, the diagnosis of RAD was often overlooked as a possible primary diagnosis. There are often comorbid disorders or personality disorders diagnosed first as RAD appeared to be more difficult to diagnose.

As reported by Hardy (2007) the attachment theory suggests infants are primed to develop close, enduring, and dependent bonds to the primary caregiver within the first

moments of life. Attachment takes place within the first five years of a child's life. It has been reported that approximately 50% of what we learn takes place within the first year. This reinforces and emphasizes the importance of attachment to the caregiver.

DSM-IV-TR Information

The *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (DSM-IV-TR) (1994) defines Reactive Attachment Disorder as a "markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care" (p. 127). The DSM-IV-TR is the source professionals use to diagnose individuals. It supports the belief that RAD is uncommon. Based on the literature, there appears to be more research available for RAD even though it continues to be a difficult disorder to diagnose. This disorder is said to be difficult to diagnose because of the lack of comprehensive tools to assess a child for RAD.

Two subtypes of reactive attachment disorder

Behaviors of the inhibited type. Children who demonstrate this subtype avoid relationships and attachments to almost everyone. This happens when a baby never had the chance to develop an attachment to any caregiver. The caregiver may not have provided the infant with comfort or support when the infant needed it the most.

The individuals diagnosed with this subtype demonstrates a lot of resistance to affection from parents or caregivers. Common characteristics include an avoidance of eye contact or physical contact, and it appears the child will seek contact and then turn away. The child appears to seek contact and then turns away. He or she fails to initiate

contact with others, and often appears to be on guard. The child will exhibit aggression, and awkwardness in social settings. He or she has difficulty being comforted, prefers to play alone, and engages in self-soothing behaviors. These children were more likely to avoid any social interaction. He or she usually withdraws from others, and avoids when others attempt to comfort. In Hardy (2007) it is mentioned there was a study where the children who were predominantly inhibited type did not have a preferred attachment caregiver or figure in their life.

Behaviors of the disinhibited type. Children who present with the disinhibited type form inappropriate and shallow attachments to almost everyone, including strangers. This subtype appears to happen when there are multiple or frequent changes in caregivers, such as in a treatment facility or transfer from foster family to foster family. The primary caregiver may have been coerced into providing affection, but really was not responsive to meet the needs of the child. Some characteristics include a readiness to go to strangers rather than showing stranger anxiety, they seek comfort from strangers. The child has an exaggerated need for help doing tasks and demonstrates inappropriate, childish behavior or may appear anxious.

Development of Attachment

Trust versus mistrust is crucial in the development of a healthy attachment to the caregiver. The infant recognizes "good touch" equals trust; and "bad touch" or "no touch" equals mistrust.

Four phases of the bonding cycle

Wilson (2001) discussed the four phases of developing an attachment. Need, arousal, gratification, and trust are the phases of bonding between a child and his or her caregiver.

Phase one. The infant signals to seek relief from the caregiver such as when he or she is hungry, has the need to be held, a wet diaper, and other forms of distress. The infant will utilize tools to lengthen the time of physical contact with the caregiver when the caregiver responds.

Phase two. As cited in Wilson (2001), this phase of the cycle begins around eight to twelve weeks old. The infant is able to discriminate between figures, and identifies a preference for a common caregiver. The infant begins to search for the preferred caregiver, and will expand his or her seeking behaviors to reaching out for the caregiver or scooting towards the caregiver.

Phase three. In the third phase, the behaviors continue through the second birthday cited in Wilson, 2001. The infant wants to be in close proximity of the chosen caregiver. He or she attempts to maintain or seek closer proximity. Some behaviors in this phase consist of the infant following the caregiver or greeting the caregiver. He or she adjusts actions based on anticipated behaviors of the caregiver.

Phase four. In the last phase, the infant gains a better understanding of independence the caregiver and determined those behaviors. This is the point at which the infant and caregiver are considered to have a healthy bond, or attachment, also cited in Wilson, 2001.

Completed bonding cycle

The bonding cycle is complete when the infant first expresses a need, and when not initially addressed, the infant will continue to cry. Once the need is met in a timely manner and continues to be consistent and appropriate, the infant receives the message "I am worthy." He or she then feels relief and gratification as his or her needs are met. In the end, trust is built as the child learned cause and effect and built connectedness to self and others. If the cycle is completed, the individual grows to develop healthy relationships, empathy, and rational thinking patterns.

Broken bonding cycle

A broken bonding cycle starts when the infant expresses a need, and is not comforted. He or she become escalated due to the unmet need and lack of comfort from the caregiver. If the need continues to not be met, the attachment problems are initiated. The infant becomes angry and terrified. Due to the need not being met, beneath all of the anger lies a deep seeded sadness. The infant feels alone and helpless. This sends a message to the infant that he or she is "not worthy." The infant learns coping skills. The gratification becomes self-soothing, paybacks, relief and release, or he or she simply stops seeking the interaction with the caregiver. It affects his or her sense of cause and effect and the child learns to only trust themselves and how to meet their own needs.

If the bond does not develop, the individual does not form relationships, let alone healthy relationships. He or she is unable to recognize or utilize healthy boundaries. The child's thinking patterns are irrational and anger management becomes an ongoing problem.

Four infant attachment styles

Secure attachment. These infants disapprove of separation from the caregiver and want to regain closeness once the caregiver returns. There is little resistance to the closeness with the caregiver, which separates this style from the other three.

Avoidant attachment. These infants demonstrate behaviors that appear to be a rejection of the caregiver. He or she ignores the caregiver who leaves and returns, and will actively avoid the caregiver even if the caregiver is attempting to have contact with the child. There is minimal agitation or stress when the caregiver leaves. The child finds comfort from a stranger without a second thought. Behaviors in this style of attachment appears to resemble oppositional defiant disorder. This is a good example of how a child with RAD can be misdiagnosed.

Resistant (insecure) attachment. These infants are preoccupied with the caregiver. The caregiver experiences a comfort and rejection from the infant. It is said those with this style of attachment demonstrate more maladaptive behaviors. The child pushes and pulls because it appears he or she would like to have a connection, however, it is awkward and uncomfortable for him or her. The children in this group appear to have more anger than those in the other attachment styles.

Disorganized attachment. This style was said to have the most correlation to psychopathology. These infants more than likely were mistreated in some manner by the caregiver. The disorganized attachment also presents the push and pull behaviors, and it creates an inner conflict for the individual with RAD. The caregiver may be the source of the distress, yet the caregiver may also be the person to comfort the infant when the

infant experiences distress. The child often contradicts themselves as they reach for the caregiver, and then turn away from them.

Comorbidity

There was further research done by Hall and Geher (2003) which described how the infant-caregiver relationship was an important part of personality development in later life. Other behaviors or diagnoses that commonly occurred along with the attachment disorder included substance abuse, conduct disorder, and obsessive compulsive disorder. Those diagnosed with reactive attachment disorder where at greater risk of demonstrating more significant violent and detrimental behaviors, and personality difficulties than those children not diagnosed with RAD.

Conclusion

There is a lot more information in regards to the diagnosis of reactive attachment disorder since Bowlby started his work in 1948, even though RAD is still said to be uncommon. It remains difficult to diagnose, and often overlooked. There are no fine tuned tools to be used to diagnose RAD.

The DMS-IV-TR explains the different subtypes, inhibited and disinhibited types of attachment. Those with inhibited type appear to be more isolated, where as those with the disinhibited type will not necessarily attach to a specific caregiver. The child diagnosed with disinhibited type will be more willing to create shallow attachments to almost everyone, and even strangers.

As mentioned previously, an infant or child diagnosed with RAD has likely experienced a high rate of neglect, sexual, physical, or emotional abuse, or other

traumatic events. These traumatic events affect the attachment cycle which is important between the infant and caregiver within the first five years of life. When it is broken, lack of trust is established. Other possible reasons mentioned include sudden separation from primary caregiver which leads to a constant interruption of the attachment pattern. A persistent disregard of the child's basic emotional need for comfort, stimulation, and affection initiates the development of an attachment disorder as the attachment between infant and caregiver was broken at a critical stage in the individual's life.

The four phases of attachment and four attachment styles have been documented which allows for a better understanding of the diagnosis. It is important caregivers working with children be observant and recognize if there is more to the obvious behaviors than that of oppositional or otherwise.

These individuals are delicate because they will push and pull in relationships, which can create stressors or disappointment with the caregiver attempting to build the bond with the child. The children diagnosed with RAD may not ever develop a relationship in the way an individual without RAD develops relationships. Continued research about this diagnosis will strengthen the understanding by caregivers, counselors, and those work with children diagnosed with reactive attachment disorder.

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Reactive Attachment Disorder

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- A complex childhood psychiatric illness that begins in infancy or early childhood
- No known cause, yet is said to be the disruption in the attachment cycle between the infant and the primary care giver
- Emotional abuse, sexual abuse, or physical abuse are all common in individuals diagnosed with RAD
- Inadequate care in an institutional setting, which include an orphanage, residential treatment, hospital, or foster care can also contribute to RAD
- Attachment takes place within the first five years of life and as soon as one month
- It is reported 50% of what we learn takes place within the first year

DSM-IV-TR Information

Reactive Attachment Disorder as a "markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care." RAD is reported to be uncommon and is said to be difficult to diagnose because there
is lack of comprehensive tools to assess a child for RAD.

Behaviors of the inhibited type

- Avoids relationships and attachments to almost everyone
- Demonstrates a lot of resistance to affection from parents or caregivers
- Avoids eye contact or physical contact
- Appears to seek contact and then turns away
- Difficulty being comforted
- Prefers to play alone
- Fails to initiate contact with others
- Appears to be on guard
- Engages in self-soothing behaviors
- More likely to avoid any social interaction
- Withdraws from others, avoids when others attempt to comfort
- Aggressive
- Awkwardness in social settings

Behaviors of the disinhibited type

- Children form inappropriate and shallow attachments to almost everyone
- Demonstrates a readiness to go to strangers and seek comfort rather than showing stranger anxiety
- Demonstrates inappropriate, childish behaviors or appears anxious
- Exaggerates the need for assistance to gain attention

Signs of RAD

- Poor eye contact, lack of tracking
- Indifference to others
- Delayed physical motor skills development
- Failure to respond to recognition of Mother or Father
- Fights for control over everything
- Cruel to animals and siblings
- Lacks cause and effect thinking
- Has preoccupation with fire, blood, or gore

Phases of Attachment

Phase one

- Signals for relief of a need to be met (i.e.: hungry, need to be held, a wet diaper, and so forth.)
- The infant will try to lengthen the time of physical contact

Phase two

- Begins around eight to twelve weeks old
- Identifies a preference for a common caregiver
- Reaches for the caregiver or scoots towards the caregiver
- Follows caregiver and greets the caregiver upon return

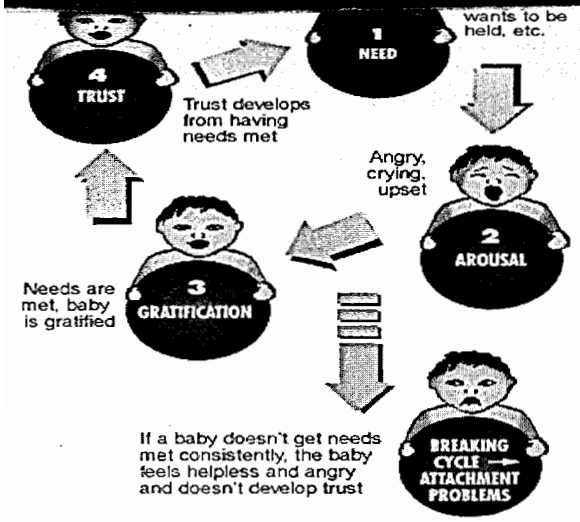
Phase three

- Behaviors continue through the second birthday, and language begins to develop during this phase
- Need for close proximity of chosen caregiver, and attempts to maintain or seek closer proximity
- Adjusts actions based on anticipated behaviors of the caregiver

Phase four

- The child understands the independence of a caregiver and is able to determine those behaviors
- A bond, or attachment, is said to be established

Trust versus mistrust: The infant recognizes "good touch" equals trust and "bad touch" or "no touch" equals mistrust. Children learn from touch, constant eye contact, and movements.



http://www.attach-china.org/cycle.html

Completed bonding cycle

- Need is expressed, and the infant escalates until the need is met in a timely manner
- With consistency the infant gets the message "I am worthy."
- The child feels relief and gratification as his or her needs are met
- Trust is built as they learn cause and effect and a connectedness to self and others
- The individual grows to develop healthy relationships, empathy, and rational thinking patterns

Broken bonding cycle

- The infant expresses a need, and is not comforted, and if this continues the attachment problems are initiated
- The infant becomes angry and terrified with a deep seeded sadness
- The infant feels alone and helpless, and the infant gets the message "I am not worthy."
- The infant learns coping skills and how to meet their own needs
  - Self-soothing, paybacks, stops seeking interaction with caregiver
  - boundaries
- Thinking patterns are irrational and anger management becomes an ongoing problem

Four Attachment Styles

Secure attachment

- Disapproves of separation from the caregiver
- Wants to regain closeness once the caregiver returns
- Little resistance to the closeness with the caregiver

Avoidant attachment

- Minimal agitation or stress when caregiver leaves
- Rejects caregiver by ignoring the caregiver when he or she leaves and returns
- Avoids caregiver even if the caregiver is trying to have contact
- Finds comfort from a stranger
- The behaviors look like oppositional defiant disorder

Resistant (insecure) attachment

- Preoccupied with the caregiver
- Push and pull behaviors, or comfort and rejection, as they would like to have the connection, but it is awkward and uncomfortable
- Maladaptive behaviors
- More anger than those in the other attachment styles

Disorganized attachment

- Most correlation to psychopathology
- More than likely are mistreated in some manner by the caregiver
- Caregiver may be a source of the distress as well as comfort to the distress, which creates an inner conflict for the infant
- Child contradicts themselves by reaching for caregiver and then turns away

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Internet Resources

http://members.tripod.com/~radclass/

http://radkid.org/

http://www.attachmentcenter.org/

http://www.attachmentdisorder.net/

http://www.attachmenttherapy.com/

For further information or questions, you may contact me at kjespy@mchsi.com