2009

Reactive attachment disorder : implications for counselors

Kim Rogers

Reactive attachment disorder : implications for counselors

Abstract

The purpose of this paper is to provide background on reactive attachment disorder. Reactive attachment disorder (RAD) is growing in diagnosis and yet it is one of the least researched disorders. This paper will discuss attachment theory, problems with the RAD diagnosis, interventions for mental health professionals, and future research ideas.

Running head: REACTIVE ATTACHMENT DISORDER

Reactive Attachment Disorder: Implications for Mental Health Counselors

Kim Rogers

In Partial Fulfillment

Of the requirements for the Degree of

Master of Arts at the University of Northern Iowa

This Research Paper by: Kim Rogers
Entitled: Reactive Attachment Disorder: Implications for Counselors
has been approved as meeting the research paper requirements for the Degree of Master of Arts

12-11-09 Darcie Davis

Date Approved Adviser/Director of Research Paper

12-14-09 Victoria Robinson

Date Received Head, Department of Educational Leadership, Counseling, and Postsecondary Education

Abstract

The purpose of this paper is to provide background on reactive attachment disorder. Reactive attachment disorder (RAD) is growing in diagnosis and yet it is one of the least researched disorders. This paper will discuss attachment theory, problems with the RAD diagnosis, interventions for mental health professionals, and future research ideas.

Reactive Attachment Disorder: Implications for Mental Health Counselors

Reactive attachment disorder (RAD) is a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) which is characterized by problems with attachment to a primary caregiver. In the past, this diagnosis was rarely seen and diagnosed. The current number of children diagnosed with Reactive Attachment Disorder (RAD) has increased greatly (Hanson and Spratt, 2000). As more and more clients are exhibiting symptoms of the RAD diagnosis it "is one of the least researched and most poorly understood disorders in the DSM" (Chaffin, Hanson, Saunders, Nichols, Barnett, Zeanah, Berliner, Egeland, Newman, Lyon, Letourneau, & Miller-Perrin, 2006, pp 80). More information is needed so professionals can accurately diagnosis and find empirically based approaches to treating clients with RAD.

It is difficult to diagnose RAD as some of the symptoms are characterized in other disorders. Some believe RAD is over diagnosed due to this problem and caution should be exhibited before labeling someone with attachment disorders. Some believe more common diagnosis such as attention deficit, hyperactivity disorder (ADHD), post traumatic stress disorder (PTSD), disruptive behavior disorders, or adjustment disorders should be considered before more rare conditions such as RAD (Chaffin, et. al, 2006).

RAD is a serious mental illness and RAD children demonstrate considerably more behavior and psychosocial problems than children without RAD (Buckner, Lopez, Dunkel, & Joiner, 2008). Hall and Geher's (2003) research suggests children with RAD score lower on empathy and children may report their personality traits in overly positive ways. It is important to help those with true attachment disorders receive treatment early.

The Mayo Clinic staff (2009) identified risk factors for RAD including institutional or foster care, frequent changes in caregivers, inexperienced caregivers, extreme poverty, abuse, long hospitalization, forced removal from a neglected or abusive hone, trauma, and parents with mental illness, substance use, depression, or anger management problems as attachment to a primary caregiver may not occur. It is important to note that not all children whose caregivers who were abusive or maltreated will develop RAD (Hanson and Spratt, 2000).

Attachment theory

RAD is characterized by failure to develop an attachment to a primary caregiver. Throughout this paper, the client will be addressed as a child as this is where most of the research is done. It is important to note, however, RAD is not limited to children but can also occur in adolescents and adults. Key attachment theorist John Bowlby proposed a disrupted relationship between mother and infant can lead to psychopathology (Miller, 1989). His work focused on how infant's attachment to primary caregivers is critical in human development. In Miller (1989) another notable attachment theorist led to significant research in attachment. Ainsworth, suggested there are attachment styles (secure, insecure, avoidant, and anxious) in her research. She suggested that children use a secure base (primary caregiver) to explore the world. Problems then arise if there is no secure base for the child who has not learned to trust. Children between eight months and three years of age have preference for specific attachment figures and begin to use caregiver's base to explore the world (Hanson and Spratt, 2000).

These theories play an important role in the diagnosis of RAD. Children are likely to receive this diagnosis because their behavior problems which are often presumed

from maladaptive relationships with primary caregivers (Spratt & Hanson, 2000). What mental health professionals need to know is how normal attachment is formed and how to help clients when this attachment has not formed and is severe enough to reach attachment disorder diagnosis.

Diagnosis

There are very few studies done on RAD disorder and the number of people diagnosed with RAD is increasing. It is important for professionals to be able to accurately diagnosis RAD early and correctly in order for appropriate treatment to be started. Most research on RAD clients is done on institutionalized children or maltreated young children (Boekamp, 2008) so this is important to keep in mind when reviewing symptoms.

The Diagnostic Statistic Manual IV edition (2000) defines reactive attachment disorder by disturbed and developmental inappropriate social relatedness before the age of five and the client has received pathogenic care by either disregard of the child's basic emotional needs, disregard of basic physical needs, or changes in primary caregiver that prevent attachments which is the presumption of why the child has disturbed behavior, and is not accounted by developmental delay or pervasive development disorder. There are two types of RAD. First, inhibited type, which is the "failure to initiate or respond developmentally appropriate to most social interactions which is characterized by excessively inhibited, hypervigilat, or highly ambivalent and contradictory responses" (DSM, 2000 p 130). In this type, clients are unable to attach to caregivers appropriately. Second, disinhibited type, which is "manifested by indiscriminate sociability with marked inability to exhibit appropriate selective attachments" (DSM, 2000 p 130). In this type,

clients may have excessive familiarity with strangers and fail to attach to a primary caregiver.

It is important not to over diagnosis RAD as it is a rare condition and typically not seen in clients who have been significantly neglected or abused at a young age. It is important for mental health professionals to distinguish from other comorbid conditions for improved diagnosis and treatment of children with attachment issues (Zilberstein, 2006). There are common overlapping symptoms. Symptoms attributed to reactive attractive disorder children are often seen in other children such as hostility, stealing, lying, bullying, lack of empathy or remorse which may lead to overdiagnosising RAD (Boekamp, 2008). Professionals need to be careful it is not a developmental disorder or disorders such as depression, ADHD, or disruptive behavior disorders (Sheperis, Renfro-Michel, & Doggett, 2003).

Some argue the DSM IV needs revision of the RAD diagnosis. Boris, Zeanah, Larrieu, Scheeringa, and Heller (1998) suggest there needs to be revision to the diagnosis, especially children under three. They also suggest RAD may be diagnosed without knowledge of pathological parental care as there may be problems obtaining information about the child's caregiver when treating the child.

When mental health professionals are conducting an assessment, it is important to get a detailed history in a variety of situations and contexts to get a full view of the client's patterns. Some warn against the use of checklists as they are not well researched. Some measures used in research are the kinship questionnaire (Wardrop & Meyer, 2009) and the reactive attachment disorder questionnaire which is reported by caregivers but not well validated (Horner, 2008).

Interventions

Caregiver's role- It is important to keep the caregivers of children diagnosed with reactive attractive disorder informed about the diagnosis, characteristics of RAD, and needs of these children.

Caregivers of RAD children may be solicited to have their children in expensive residential treatment programs (Hanson and Spratt, 2000). It is important to provide a realistic assessment of the client's needs so caregivers can be as informed as possible as to the treatment of their child. It is also important to involve the caregivers in therapy as attachment to the caregiver is necessary goal as well as safety for all members of the family.

Caretakers need to be aware of children's rights and gain knowledge on how to represent their children in Individual Education Plan (IEP) meetings in education so the children's educational needs are addressed (Sheperis, Renfro-Michel, & Doggett, 2003). It is common for RAD children to exhibit behavioral problems which may affect their education. RAD children have specific needs and caretakers should be aware of their rights to make sure their children have educational plans to best meet their needs.

Mental Health Interventions-Boekamp (2008) and Hanson and Spratt (2000) emphasize there are no known effective treatments for RAD children only interventions which provide a foundation for treatment. Some argue there are treatments to be avoided.

> "The controversial interventions associated with the attachment therapy movement, may also be known as "holding therapy," "rebirthing therapy" or "rage reduction therapy". These interventions are based on the premise that early

trauma experienced by children with RAD results in rage which the child attempts to suppress which, in turn, leads to superficial emotions and relatedness, manipulative an coercive behavior, as well as other antisocial behaviors." Boekamp (2008, pp3).

The theory behind this type of therapy is explained in the controversial book Holding Time by Margaret Welsh. She explains that a child is held to allow direct eye contact with the child and caregiver while controlling a child's attempts to leave. This progress goes through several states including confrontation, rejection, and resolution. There have been several reports of child death as a result of holding therapy and there is disagreement to the cause of therapy as some argue therapy technique is done incorrectly (Chaffin, et. al.) Some argue the general concept of eye contact and holding a child help nurture attachment may advantageous. Buckner, et. al. (2008) explained children who received holding therapy had decrease in aggressive behaviors but participants were not randomly assigned to treatment conditions which may influence results. Others believe this type of therapy may recreate trauma for children.

Another form of attachment therapy is used called theraplay. In the book chapter by Wardrop and Meyer (2009) research was done on theraplay in which the authors thought data would support Theraplay's reputation for effectiveness of thirty-five years of existence but found only a small number of studies were done on theraplay. Further research is needed in theraplay effectiveness to validate its effectiveness.

The Theraplay Institute (Sage Internet Solutions, Inc., 2009) approach assumes human motivation is to relate to one another, change is possible, and change is to create more positive relationship with the child and caregiver(s). The concentration in this

therapy is to help foster attachment between the child and caregiver. Also important to note is that "it is essential to return to the stage at which the child's emotional development was derailed and provide the experience which can restart the healthy cycle of interaction" (Sage Internet Solutions, Inc., 2009). So if a child was maltreated as an infant, therapy must go back and simulate normal infant-mother interactions to help provide a healthy interaction at the level where development was delayed.

Another form of therapy which has researched in attachment disorder clients is Behavioral Management Treatment (BMT). BMT which provides caregivers with psychoeducation about misbehavior and parenting skills in a study resulted in decreased problematic behavior and increased compliance with caregivers and play with peers (Buckner, et. al., 2008). The focus of this therapy is to help manage behaviors and provide a structured and consistent environment for the child to foster growth. The focus is on how to address maladaptive or socially inappropriate behavior to keep the child and other safe. For example, it is important to help disinhibited type reactive attachment clients learn behaviors skills to help keep them safe as a symptom of this diagnosis is excessive familiarity with strangers which could lead a child to danger.

These are important skills to learn and found in a variety of texts. "Traditional attachment theory holds that caregiver qualities such as environmental stability, parental sensitivity, and responsiveness to children's physical and emotional needs, consistency, and a safe and predictable environment support the development of healthy attachment" (Chaffin et al., 2006, pp 77). It is logical to assume this is important to help those with abnormal attachment styles and should be incorporated in therapy.

There are other key aspects in treating attachment disorders. Hanson and Spratt (2000) suggest the importance of noticing insecurely attached children early in age, making sure the child is in a secure environment in which nurturing can take place, working with the caretakers on parenting skills, focusing on coping skills for the family, and maintaining the least restrictive and intrusive level of care. Parents should be educated in providing a stable environment for their child and help the child with appropriate coping skills. Parents should also be educated on attachment disorders and how to notice symptoms of attachment disorders. This is especially important to inform guardians in the foster care system, adoption, and institutionalized children as they may be at a higher risk to have problems with attachment with a primary caregiver. It is also important to inform adults that this is a rare condition and risk factors such as no visible primary caregiver in a time which attachment is crucial, does not mean the child will develop an attachment disorder.

Another key aspect of treatment is involving the caretaker in the process if at all possible. This may not be possible if there is no primary caregiver available, willing, or if the RAD client is an adult. If possible it is important to help aid healthy attachment in with caretakers as young as possible. It is important to work with the caregivers in treatment as well as children and work on principles of attachments (Horner, 2008). Mental health professionals believe paying attention to the caregiver and child relationships and help strengthen this relationship as it is important in treating children with attachment problems.

The American Professional Society on the Abuse of Children (APSAC) task force on attachment therapy recommended guidelines for assessment of RAD. Chaffin, et. al.,

2006, recommends the following guidelines. It is critical to assess the client correctly and as soon as possible. The APSAC assessment guidelines include information about the patterns of behavior over time and across situations, cultural issues need to be considered, not relay on checklists, professionals need to have considerable knowledge in the diagnostic process, professionals need to consider more common disorders before rarer ones, assessment should include the caregivers factors, rule out other conditions, and a reactive attractive disorder diagnosis cannot be made on maltreatment of the child alone. These are important to consider as to not overdiagnosis or underdiagnosis clients with RAD. It is important to catch attachment problems as soon as possible to begin treatment.

The APSAC also recommends these treatment guidelines for mental health professionals (Chaffin, et. al., 2006). Treatment will not cure attachment problems but there can be considerable promise to a more healthy attachment and decrease in maladaptive and socially inappropriate behaviors. Treatment should not be used with absence of proven benefit and where there is a risk of harm, predictions of children to be psychopaths in the future cannot be made due to a children's behavior, avoid interventions that portray children in negative ways as this may promote abuse, distress in therapy needs to be taken seriously every time, evidence based therapy should be considered first, and treatment should involve caregivers.

These assessment guidelines and treatment background can give a basis on a solid foundation for treatment. It is important to have knowledge of potentially harmful therapies and research based methods which hold promise to help clients with reactive attractive disorder. There is a great need for more research in the field.

Conclusion

As stated previously, there are very few studies that examine clients with reactive attachment disorder. Specifically, there are very few studies aimed at therapy and intervention with reactive attachment disorder. This is vitally important to help reach this population and help with the attachment to the primary caregiver. This is especially important since there is such a problem with abuse and neglect in the world today as this is a risk factor for (Reactive Attractive Disorder) RAD. Most studies are aimed at children. There is limited research on the treatment of adolescents with RAD (Sheperis, Renfro-Michel, & Doggett, 2003). There is also a lack of knowledge in how to help adults who have RAD and the different needs at this developmental level. This population is largely ignored. It is also important for further research needed as most studies have generally been retrospective in nature (Hanson and Spratt, 2000). Most research are case studies and not done with a large number of participants. There are also very few studies examining patterns of RAD over time (Horner, 2008).

Clearly, there is much research needed to accurately diagnosis and treat reactive attachment disorder. However, we can have a solid base of knowledge on reactive attachment disorder and the two types. Inhibited type is characterized by an inability to attach to caregivers and disinhibited type who do not attach to caregivers and have excessive familiarity with strangers. Disinhibited type is characterized by excessive familiarity with strangers. Characteristics of reactive attachment disorder include a lack of empathy, lying, stealing, hostility, and an inability to attach to primary caregivers.

It is critical that professionals know how to accurately diagnosis RAD as the number of people diagnosed with this disorder is increasing at a rapid rate. It is also

important for professionals to be able to identify the symptoms of RAD early in age as the earlier in the symptoms are caught, the sooner treatment can start. There is some research about treating attachment disorders such as theraplay, behavior management, and other attachment therapy specialties. More research needs to be done to provide professionals with more knowledge on effective treatment.

References

American Psychiatric Association. (2000). Reactive attachment disorder. *Diagnostic and statistical manual of mental disorders* (4th ed. text revision, pp. 130). Washington, D.C.: Author.

Boekamp, J. (2008). Reactive attachment disorder in young children: current perspectives on diagnosis and treatment. *The Brown University Child and Adolescent Behavior Letter, 24,* 1.

Boris, N., Zeanah, C., Larrieu, J., Scheeringa, M., & Heller, S. (1998). Attachment disorders in infancy and early childhood: A preliminary investigation of diagnostic criteria. *American Journal of Psychiatry*, *155*(2), 295.

Buckner, J. , Lopez, C. , Dunkel, S. , & Joiner, J. (2008). Behavior management training for the treatment of reactive attachment disorder. *Child Maltreatment*, *13*(3), 289-297.

Chaffin, M., Hanson, R., Saunders, B., Nichols, T., Barnett, D., Zeanah, C., Berliner, L., Egeland, B., Newman, E., Lyon, T., Letourneau, E., & Miller-Perrin, C. (2006). Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreat*, *11* (1), 76.

Hall, S. & Geher, G. (2003). Behavioral and personality characteristics of children with reactive attachment disorder. *Journal of Psychology, 137*(2), 145-162.

Hanson, R. & Spratt, E. (2000). Reactive attachment disorder: What we know about the disorder and implications for treatment. *Child Maltreat*, *5*(2), 137.

Horner, G. (2008). Reactive attachment disorder. *Journal of Pediatric Health Care, 22* (4), 234-239.

Mayo Foundation for Medical Education and Research (2009). *Reactive Attachment Disorder*. Retrieved June 19, 2009, from The Mayo Clinic Website: http://www.mayoclinic.com/health/reactive-attachment-disorder/DS00988

Miller, P. (1989). *Theories of Developmental Psychology* (Second Edition). W.H. Freeman and Company.

Sage Internet Solutions, Inc. (2009). *What is theraplay.* Retrieved July 20, 2009, from The Theraplay Institute Website: http://www.theraplay.org/8373/index.html

Sheperis, C., Renfro-Michel, E., & Doggett, R. (2003). In-home treatment of reactive attachment disorder in a therapeutic foster care system: A case example. *Journal of Mental Health Counseling*, *25*(1), 76-88.

Wardrop, J. & Meyer, L. (2009). Research on Theraplay Effectiveness. In E. Munns, *Applications of Family and Group Theraplay* (pp. 17-24). Plymouth, UK: Rowman & Littlefield Publishers, Inc.

Welsh, M. (1989). *Holding time: How to eliminate conflict, temper tantrums, and sibling rivalry and raise happy, loving, successful children.* New York: Fireside.

Zilberstein, K. (2006). Clarifying core characteristics of attachment disorders: A review of current research and theory. *American Journal of Orthopsychiatry*, *76*(1), 55 64.