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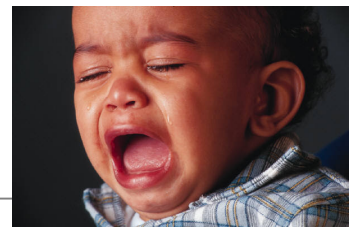
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## REACTIVE ATTACHMENT DISORDER: DEVELOPING A DEVELOPMENTAL PERSPECTIVE

Johnathan Sumpter

ABSTRACT: Reactive Attachment Disorder is a relatively young disorder. Researchers are just beginning to hash out the implications of this disorder on current children and future generations. However, there is much needed from criteria setting and researching leadership to mediate the process of gaining ground in assessing and treating this disorder. This meta-analysis will provide an overview that will point out the diagnostic ambiguities, theoretical conflicts, and disjointed research of the previous decade's work on RAD.



Reactive Attachment Disorder:

Developing a Developmental Perspective

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Counseling 6020: Development Through the Lifespan

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## **Introduction**

The attachment theories of John Bowlby may have initiated an impetus for a paradigmatic shift in counseling psychology, which is still being clinically interpreted over three decades later. The attachment between infant and primary caregiver is shown to cause a lasting effect on an individual's development, and has been empirically validated since the mid twentieth century (Wimmer, Vonk, & Bornick, 2009). Diagnoses of attachment related disorders were included in the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (currently the DSM-IV-TR) since the early 1980's (Mukaddes, Bilge, Alyanak, & Kora, 2000) have been growing in diagnostic frequency (King, & Newnham, 2008; Millward, Kennedy, Towlson, & Minnis, 2006), and even spawned a therapeutic school of thought: *Attachment Therapy* (Wimmer, et al., 2009).

Despite the continued growth of attachment theories, specific disorders, such as Reactive Attachment Disorder (RAD), are found (or perhaps lost) somewhere in the midst of Bowlby's experience and philosophy, diagnostic criteria, current research and literature, and the Attachment Therapists' practice and instrumental measures (King, & Newnham, 2008). This meta-analysis will provide a developmental overview, pointing out diagnostic ambiguities, theoretical conflicts, and disjointed research of RAD.

## **Literature Review**

### **Development of Theoretical Perspective.**

#### **Early Years.**

RAD is diagnosed as presenting symptoms before the age of 5 (American Psychiatric Association, 2000). Along the same theoretical vein as Erik Erikson's first psychosocial

stage of “trust vs. mistrust;” John Bowlby places emphasis on early infant relationships. The base concept of Bowlby’s theory is that infants need to form a strong and nurturing bond with their primary care giver during the first year of their life. The emotional and psychological wellbeing of the child is based on a consistent, nurturing, emotionally responsive caregiver who will also be the foundation for developing social/emotional reciprocity (Bowlby 1982).

Viewing RAD from Erikson’s model of psychosocial developmental stages, a poor child-caregiver attachment would cause a deficiency in human, psychological, and emotional attachment (Bowlby); which causes an incomplete or non-mastered early stage of *Basic Trust* (King, & Newnham, 2008). When a child has continually unmet needs, he or she develops a mistrusting attitude towards caregivers. In other words, this basic foundation of mistrust translates into a sense of ambiguity for personal emotional, psychological, and physical wellbeing (Bowlby, 1980, 1982, and 1973).

Within Bowlby’s Attachment theory, there are five different attachment styles. Secure attachment is when the infant finds a secure base within primary caregiver relationship. About 60% of the general population falls into this category, while the insecure patterns account for 40% of the general population (Berk, 2010). While the exploration of the various styles is outside the scope of the current paper, the DSM and ICD criteria of RAD seem to form from severely pathological, insecure types. No studies found have categorized RAD diagnosable criteria into Bowlby’s attachment styles. From Bowlby’s perspective, these attachment styles reverberate throughout the child’s life.

### **Development of Childhood into Adulthood.**

RAD has been shown to affect the emotional functioning and wellbeing of the middle childhood to adolescent years, but has not been researched beyond this point; no longitudinal studies have been made to see effects into later adulthood (Millward, et al., 2006). Of the research that has been done, conflicting results seem to be all that is yielded (Javier, Baden, Biafora, & Camacho-Gingerich, 2007). A possible issue with researching RAD is defining diagnosis for RAD.

### **Diagnosis.**

The DSM-IV-TR bounds the essence of RAD as “markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care” (American Psychological Association, 2000, p. 127). RAD has two types of presentation. First, the *Inhibited Type* is where the child continually fails to respond to social interactions in a developmentally appropriate way with hypervigilant, and/or highly ambivalent responses. The second type is the *Disinhibited Type*, where the child exhibits indiscriminate sociability or lacks selectivity in choosing attachment figures (American Psychological Association, 2000).

Diagnosing RAD is further confounded by the International Classification of Diseases’ (ICD-10) nomenclature for the disorder. Instead of Inhibited and Disinhibited, the ICD-10 labels 1) Reactive Attachment Disorder, is the same as the Inhibited form of RAD in the DSM, and adds four specific criteria not listed by the DSM; and 2) Disinhibited attachment disorder, with an additional two criterion (Minnis, Marwick, Arthur, & McLaughlin, 2006). Both the DSM-IV-TR and the ICD-10 provide criteria for a categorical model of dysfunction, whereas Bowlby’s theory was a spectrum of psychosocial functioning

(King, & Newnham, 2008). Things become even more difficult when diagnostic criteria from practicing Attachment therapists.

Attachment therapists view attachment disorders more as a level of child energy expenditure (King, & Newnham, 2008). Therapists give witness to children with RAD developing antisocial behavior, lacking in conscience understandings, impulse control problems, elevated aggression, apathy, irresponsibility, often developing a sense of psychic homelessness (not having an emotional connection of belonging or connection), and self-destructive behavior (Javier, et al., 2007).

Due to similarities in presentation, the APA (2000) warns the clinician to be wary of confusing RAD with the following: Mental Retardation, Autism or other PDD, ADHD, Conduct Disorder, and Oppositional Defiant Disorder. The DSM criterion have a lot of gray area left to clinician discretion; ICD has more specific disorder focused criteria; while Attachment theorists are more concerned with relationship development than disorder (King, & Newnham, 2008). Still, a commonality between diagnostic schools of thought, note that behaviors cannot otherwise be diagnosed as a mental deficiency or developmental disability (i.e. MR or PDD), and is usually found in homes where there is a persistent disregard for the child's basic emotional needs for comfort, stimulation, and affection (American Psychiatric Association, 2000).

Fitting two DSM or ICD criteria into four insecure attachment styles is not a focus of clinical diagnosis; rather, styles tends to be the focus of practicing Attachment therapeutic processes. Bowlby's philosophical theories suggest a spectrum of psychosocial functioning (King, & Newnham, 2008; Bowlby, 1980, 1982, and 1973), whereas clinical diagnoses provide categorical view of a disorder. Whether viewing Attachment Theory as a spectrum

of social functioning, or an “all-or-nothing” disorder in the making (Javier, et al., 2007), current ambiguous criteria, practice, and research all conflict.

### **Developmental Implications.**

The DSM-IV-TR states that the influence RAD plays on development varies, depending on caregiver relationships and the timing/nature of interventions. Amelioration is possible, but the disorder could very well continue to follow a dysfunctional course (American Psychiatric Association, 2000), to what extent, nature, or course, is unknown. Most researchers view RAD as a disorder found in the foster care system, therefore most research follows from that population. Taking a quick look into the statistics of this narrow perspective still shows a vast number of individuals who may lack in future treatment if more research is not done.

The overall prevalence of mental health problems foster or residential care children in 2006 was 45%, however with the ambiguity of current criteria, the prevalence of RAD in this percentage is still unknown (Minnis, et al., 2006). At the close of 2006, the amount of children in the public foster system was 799,000. Only 51,000 of these children were placed with adoptive families, and 509,000 children were either waiting to be placed, or were in foster care. Those who were returned to families counted close to 300,000 (US Department of Health and Human Services, 2008). These statistics would point to approximately 360,000 children suffering from mental illnesses in the social service community. Assuming that these children are not the only children at risk for RAD, understanding the developmental implications is paramount in treating future generations.

One recent study showed gender differences of antisocial behavior from adopted children diagnosed with RAD, aged 12 to 15 years old. Boys were more likely to steal, lie,

cheat, participate in vandalism, etc. Whereas, adopted girls tended to be more cruel and aggressive against people and objects. This study also found that 10% of all children who were adopted at later ages, in the foster care system longer, were diagnosed with RAD (Javier, et al., 2007). However, a similar study found boys struggling more by hyperactivity and aggressiveness, attention and thought problems, as well as anxious and withdrawn depressive tendencies. Girls, on the other hand, only out performed boys in antisocial behaviors of somatic issues and rule breaking (Cappelletty, Brown, & Shumate, 2005).

Other groups of children that may also be at risk of RAD are children whose parents have alcohol, substance, and mental health problems. These children may experience a chaotic and, at times, dangerous home environment with unavailable parents who do not respond to the child's psychological or physical needs (Minnis, et al., 2006). One concern for this is learned behaviors translating into repetition to future generations when these children become parents. Another future oriented problem might be correlations between RAD and recidivism rates in the penal system.

Behaviors that are described as the "disorganized pattern," have been shown to be present in 80% of abused children and to be highly correlated with childhood aggression (Minnis, et al., 2006). There is show to be an association between early childhood abuse and/or neglect and future adult criminality (Minnis, et al., 2006). Less than one-fifth of serious criminal offenders have not experienced some form of childhood abuse. An intuitive, yet un-researched, association could exist between early family relationships, the development of RAD, and developing serious criminal offending (Minnis, et al., 2006)<sup>1</sup>.

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<sup>1</sup> Bowlby began a longitudinal project on forty-seven thieves, which was followed up this past year. Unfortunately, this article is inaccessible to poor researching college students.



The research body for RAD is relatively young, and still forming. There are many different researchers, with many different perspectives on development, disorder, and dysfunction. The fullness of the *Developmental Implications* for RAD will continue to be informed as the research corpus continues to grow.

### **Current Research.**

Theoretically speaking, attachment is the “keystone on which other developmental tasks rest” (Javier, et al., 2007). However, despite the increase of clinical popularity for RAD, little empirical research has been done on this disorder; due in part to its subjective definition and often-uncommon clinical manifestation (Cappelletty, et al., 2005). RAD remains an underused, under-researched, and often discredited disorder (Minnis, et al., 2006). Another possibility of lack of research is the stigma of RAD affecting a narrowly specific population.

Many researchers see RAD solely as an issue for adopted children, however, while this population is at greater risk (Millward, et al., 2006), there may be more cases of RAD and attachment disorders in the general population than current diagnostic criteria may allow (Wimmer, et al., 2009). One Turkish study found a multitude of misdiagnoses of Pervasive Developmental Disorders (PDD), instead of RAD, in upper to middle class homes, with a majority of stay at home mothers. These results have been attributed to maternal depressive symptoms causing neglectful behavior (usually caused by stress an unplanned pregnancy), the child’s overexposure to television, and challenge the *foster system only* stigma of RAD (Mukaddes, et al., 2000). It could be said that Turkish society may play a part: however, Bowlby showed attachment across cultural bounds around the world (Bowlby, 1982). This statistic is jarring in regards to understanding the disorder, as well as

the researching process of this disorder. When viewing the literature, there is a gamut of theoretical and empirically driven perspectives.

Within the current diagnostic criteria, some researchers assume that attachment theory is not sufficient, observing securely attached children acting disinhibited in social settings, and vice versa; and are calling for a reevaluation of RAD diagnostic criteria (Millward, et al., 2006). Various researchers see RAD within current criteria, as a possible first step to Conduct Disorder (Minnis, et al., 2006). Some researchers, and even prominent RAD screening tools, such as the Randolph Attachment Disorder Questionnaire (RADQ), use a blending of theory in conjunction with criteria for Conduct or Oppositional Defiant Disorder to screen and treat RAD (Cappelletty, et al., 2005). Yet, still other researchers take a scientific biopsychosocial model of viewing RAD: i.e. traumatic experiences may have a physiological effect on biological and neuro-chemicals structures in the brain. These neurobiological effects of neglect may be more detrimental to the child than the impact of abuse and related trauma (Corbin, 2007).

RAD is being studied from a Systemic perspective for links between Post Traumatic Stress Disorder (PTSD) and Borderline Personality Disorder (Kasenchak, 2003). There are still more researchers and theorists who point to more pragmatic explanations of RAD. These theorists hypothesize that the issue is with the quality of interaction, or “pathogenic care,” rather than pathology built by the lack of psychological attachment (Mukaddes, et al., 2000). For example, a child does not learn to talk, interact, or be social, if no one is modeling this for them- rather than a social or mental deficiency as a sense of belongingness.

The vast majority of studies in this meta-analysis express concern towards clinician/researcher inexperience in relating with, diagnosing, and treating RAD. As stated, the general population experiencing RAD may be underrepresented in statistics (Wimmer, et al., 2009; Mukaddes, et al., 2000). If clinicians/researchers lack in recognizing and assessing RAD and AD, the developmental implications, and chance for intervention may be slipping by.

### **Discussion**

RAD seems to lurking in the abyss, somewhere between a theoretical spectrum of psychosocial attachment, a categorical *black-and-whiteness* of dysfunctional disorder, and a pragmatic non-emotional modeling of cognitive-behavioral learning. Every theoretical perspective seems to throw their two cents in, but come up two cents poorer, as the money pit seems to have no boundaries or agreeable diagnostic/therapeutic criteria. The current research on RAD simply shows the proliferation of opposing theoretical factions and a torrent of confused, conflicting statistics.

While Bowlby viewed attachment as a base for development, the DSM-IV-TR and ICD-10 only give mention to possible continuation of dysfunction in development. The DSM and ICD contribute to ambiguity rather than servicing the purpose of providing diagnostic commonality. Researchers find themselves alienating with developmental theoretical schools of thought, than any form of pure research. Every researcher in this study points to fellow RAD researchers and claim, “inexperienced researchers” looking in the wrong places. Every researcher has empirical evidence to back their theories and discredit opposing theories. This vagueness of diagnostic criteria causes an opaque research premise, providing nothing clinically solid to stand on.

Most researchers view RAD as strictly existing in foster care systems than in general public, but many children in the general public before being taken into the foster care system. The literature would seem to point to the ineptness of the foster care system, rather than a developmental disorder. However, one study points out the efficacy of foster care workers as the primary individuals to combat RAD (Millward, et al., 2006). Researchers show relationship to poor attachment in criminality, yet it is hard to believe that over four-fifths of the prison population being from the foster care system (Minnis, et al., 2006), or all having been diagnosed with RAD. Another issue with this narrowed focus is the Turkish study that focused on middle to upper class children with stay at home mothers (Mukaddes, et al., 2000).

The issue of misdiagnosis is intriguing. A great many individuals may be underserved due to the apparent lack of “experienced” clinicians and researchers, the uncommon presentation (i.e. tunnel vision focus of clinicians), and clinician confusion between Mental Retardation, Autism or other PDD, ADHD, Conduct Disorder, and Oppositional Defiant Disorder diagnoses (American Psychiatric Association, 2000), with the presentation of RAD. Perhaps the entire concept of RAD should be revamped.

The five attachment styles suggest a spectrum of psychosocial functioning that spans the gamut of interpersonal relationships. Attachment therapists would be focused on relationships before focusing on disorder. Those who ascribe to DSM standards may view attachment only in the strict relationship with individuals who suffer from a pathological attachment in RAD or AD. The former therapy is multifaceted, where the latter dismisses the importance of relationships in psychological development across the board. However,

neither theory seems to have a grasp on what is happening in the individual suffering from RAD.

Perhaps RAD and AD are found somewhere between the elements of these warring theories. Perhaps attachment has a major role to play in the development of the psyche. Therapists and researchers alike may be able to incorporate pragmatic and theoretical implications into their material.

### **Future Directions**

#### **Developing a Developmental Perspective.**

The current body of research of RAD is theoretically oriented, with very few actual controlled studies of the disorder. The most necessary thing for RAD's future development is continued controlled research. The most important aspect would be providing clear diagnostic criteria, but as has been displayed, research is just beginning to scratch the surface of understanding RAD. For example, if RAD shows positive links between Post Traumatic Stress Disorder (PTSD) and Borderline Personality Disorder (Kasenchak, 2003), and AD is shown to have corollaries between other disorders, Attachment Theory/therapy may also provide different epidemiological understandings, criteria, and treatments of other DSM-IV-TR disorders.

Developing RAD as a clear-cut disorder of functioning, or a spectrum of attachment (much like the ever gaining popularity of the Autism spectrum), will help both clinician and researchers. Either way, continued research should also focus on understanding the implications of attachment and RAD in the perspective of developmental growth. To do this effectively, longitudinal studies are a must for a full picture of RAD and AD development. Continuing to develop understandings of attachments within the foster care system, as well

as the penal system, may not only provide good service, but also cut down on governmental spending to provide more and more services such as these, and provide light into a population shown to be at greater risk for this disorder.

Understanding the developmental implications of attachment within the general public will provide more services for those with existing attachment issues, as well as provide preventative measures for parents for years to come. Looking deeper into the future, as society continues to develop more technological connections, and perhaps decrease interpersonal connections (attachment), understanding attachment theory's effect on function and pathology may be a crucial aspect of future generations' wellbeing.

### **Conclusion**

While Bowlby's theory may not be all-inclusive (nature/nurture and all), it does provide a paradigmatic shift in focus for mental health practitioners and researchers. Researchers must continue to research effect, versus strictly theory. Theorists must continue to theorize with this raw research effect. The scientific method should not fall prey to the long lasting psychology tradition of *Freud/Alderian-est* theoretical allegiance feuds. Perhaps there is simply too little data on this topic to draw a concise opinion; perhaps we cannot take the humanity out of research data. However, this body of research is being pulled in so many different directions, it would be hard for any practicing clinician to know how to spot, much less what to do with individuals presenting with RAD symptoms. Finding some common ground may gather more understanding, provide more advocating backers, and progress to a quicker, more informed understanding of this disorder's effect on society. All of this will come with time, experience, and increased public/clinical awareness of presenting symptoms.

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**Appendix:  
Diagnostic Ambiguity**

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**Table 1** a summary of and comparison between the two diagnostic classifications of RAD

DSM-IV	ICD-10
<p><i>Key feature</i> Disturbance of social relatedness in most contexts associated with grossly pathogenic care.</p> <p><i>Course</i> Onset in first 5 years. Persistent but remission possible in appropriately supportive environment.</p> <p><i>"Inhibited form"</i></p> <ol style="list-style-type: none"> <li>1. Excessively inhibited or hypervigilant social interactions</li> <li>2. Ambivalent or contradictory responses</li> </ol> <p>No equivalent No equivalent No equivalent No equivalent</p> <p><i>"Disinhibited form"</i></p> <ol style="list-style-type: none"> <li>1. Diffuse attachments</li> <li>2. Excessive familiarity with strangers</li> </ol> <p>No equivalent No equivalent</p>	<p>Abnormalities in social relationships associated with severe parental neglect, abuse or serious mishandling.</p> <p>Onset in first 5 years. Persistent but reactive to changes in environmental circumstances.</p> <p><i>"Reactive attachment disorder"</i></p> <ol style="list-style-type: none"> <li>1. Fearfulness and hypervigilance which do not respond to comforting</li> <li>2. Contradictory or ambivalent social responses particularly at partings and reunions</li> <li>3. Poor social interaction with peers</li> <li>4. Aggression towards self and others</li> <li>5. Misery or apathy</li> <li>6. Growth failure in some cases</li> </ol> <p><i>"Disinhibited attachment disorder"</i></p> <ol style="list-style-type: none"> <li>1. Diffuse, non-selectively focussed attachments in early childhood</li> <li>2. Attention-seeking and indiscriminate friendliness in middle childhood</li> <li>3. Poorly modulated peer interactions</li> <li>4. May be associated emotional or behavioural disturbances</li> </ol>

**Behavior Variance of Children with RAD:**

**Results for Child Behavior Checklist Scales for Male and Female Participants**

