

Recognizing and Treating Reactive Attachment Disorder

Peter M. Lake, MD

Abstract

Reactive attachment disorder is one of the most complex childhood psychiatric disorders. It develops from disrupted or pathogenic caregiver relationships during birth to three years and can leave a child unable to establish healthy relationships with family, caregivers and peers. Early intervention is essential to prevent lifelong behaviors of developmentally inappropriate social relatedness. This article presents information on why RAD can be difficult to diagnose and provides key behaviors that can distinguish RAD from other childhood psychiatric disorders. The article also includes behavior management techniques for parents or caregivers of children with RAD, an overview of treatment methods, and the importance of having a treatment provider who specializes in childhood psychiatric disorders and is experienced in diagnosing and treating RAD.

Author Biography

Peter M. Lake, MD, a board-certified child and adolescent psychiatrist, is the Medical Director of the Rogers Memorial Hospital–Oconomowoc campus and the Child and Adolescent Services of Oconomowoc. He is a frequent lecturer and consultant to schools, social service agencies, and case management systems. For more information on Rogers Memorial Hospital treatment programs, visit www.rogershospital.org.

Introduction

Reactive attachment disorder (RAD) is a complex childhood psychiatric illness that begins in infancy or early childhood. While the exact cause is unknown, RAD is thought to stem from a disruption of the exclusive and unique relationship between a child and her/his primary caregiver.

As defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), children with RAD have developmentally inappropriate social relatedness as a result of pathogenic care. This negligent care typically includes at least one of the following: persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection; persistent disregard of the child's basic physical needs; or repeated changes of the child's primary caregiver that prevents the child's formation of stable attachments (APA, 1994). The DSM-IV further states that this inappropriate social relatedness is presented in one of two behaviors:

1. Inhibited RAD, where there is persistent failure to initiate and respond to most social interactions in a developmentally appropriate way and shows a pattern of excessively inhibited, hypervigilant, or highly ambivalent responses.
2. Disinhibited RAD, in which there is a pattern of diffuse attachments, indiscriminate sociability or a lack of selectivity in the choice of attachment figures (APA, 1994, p. 250).

RAD does not seem to favor a certain gender, race, nationality, or socioeconomic status. Evidence that children have problems with emotional attachment can surface even before their first birthday. Symptoms may include severe colic and/or feeding difficulties, failure to gain weight, detached or unresponsive behavior, and difficulty being comforted (Maldonado-Duran, Helmig, Lartigue, 2003).

Diagnostic Concerns

Diagnosing RAD is complicated because its behaviors can be similar to those associated with other childhood disorders, such as conduct disorder, oppositional defiant disorder, post-traumatic stress disorder and separation anxiety disorder. What differentiates RAD from these disorders is a history of attachment disruptions and grossly pathological care, as well as a positive response to therapeutic intervention (APA, 1994).

No current studies of the frequency or prevalence of attachment disorders in children exist, and the estimated rate of occurrence varies

by source. A position statement on RAD by the American Academy of Child & Adolescent Psychiatry (AACAP) states the condition “affect(s) a small number of children” (2002, p. 1). However, a Tulane University study of RAD among maltreated toddlers who had been removed from their parents and placed in foster care showed an occurrence rate of 38-40 percent. This same study also stated “... using categorical and continuous measures, both types of RAD (emotionally withdrawn/inhibited and indiscriminate/disinhibited) can be reliably identified in maltreated toddlers (Zeanah, et. al, 2004, p. 1).

In 2000, an American Academy of Pediatrics (AAP) Committee on Early Childhood and Adoption and Dependent Care stated “Greater numbers of young children with complicated, serious physical health, mental health, or developmental problems are entering foster care during the early years when brain growth is most active.” (p. 1145). A report by the U.S. Department of Health & Human Services Administration for Children & Families (2005) showed that of the more than 523,000 children in foster care in 2003, 30 percent were between the ages of birth to five. The average length of stay within the foster system was 18 months, but the number of placements per child during that time was not listed.

The degree to which an interrupted caregiver relationship can affect a child’s mental and physical development was demonstrated in a 1993 case study of Shannon, a four-year-old girl placed in temporary foster care by child protective services. Several children had died under mysterious circumstances while in the care of Shannon’s mother.

Shannon exhibited mild delays in fine and gross motor skills, but her performance was most delayed in areas of language, self, and social relatedness. Her vocabulary was about 20 recognizable words and she could not follow simple verbal instructions. Shannon was not toilet trained and could not feed herself with a spoon. She was at the 15th percentile for height and the 10th percentile for weight. Affectively, she was anxious, depressed, and apathetic. As stipulated in DSM-IV, a response to therapeutic intervention is considered confirmatory evidence for the diagnosis of RAD. Once in a supportive setting, Shannon demonstrated both marked developmental and physical improvement. This response to treatment approaches like

this aids in understanding how RAD differs from other disorders, and should continue to be a marker for the diagnosis (Richters & Volkmar, 1994).

Stages of RAD Development

The first stage of emotional development is *trust of caretaking*. This stage occurs during the first year of life, and during this time a child develops the ability to attach or bond emotionally to a primary caregiver. The infant feels a need (e.g., hunger, comfort) and enters a state of high arousal (e.g., crying). The caregiver meets the infant's needs (e.g., food, cuddling). This gratification relaxes the infant's tension and builds the infant's trust in, and attachment to, the caregiver. The necessary ingredients for development of basic trust and attachment during the first year are eye contact, food, motion, touch, verbal contact, emotional contact, and physical contact. (Erikson, 1985) writes, "The general state of trust ... implies not only that one has learned to rely on the sameness and continuity of the outer providers, but also that one may trust oneself ... and that one is able to consider oneself trustworthy..." (p. 248).

Around 36 months, a child who has experienced this consistent reassurance and emotional support with a primary caregiver begins to develop what psychologist Margaret Mahler terms *object constancy* (Mahler, Pine, and Bergman, 1975). As the child receives the mother's eye contact, smiling expressions, and mirroring, the child internalizes that the mother is reliable and a source of safety. This confidence that the mother will return increases the child's ability to tolerate separation from her and to interact with others in her absence. The result is that by the age of three or four years, children raised in a consistent, supportive environment are able to regulate their emotions and empathize with others (Mahler, Pine, and Bergman, 1975).

Conversely, children from birth to 24 months who have developed RAD due to abuse and/or neglect often experience unmet developmental needs. These children cannot self-soothe and lack impulse control and empathy for others. From about age five through the teen years, children with RAD may exhibit temper tantrums, mood swings, stealing, and self-injurious behavior, as well as coexisting

ADHD and depression. RAD children may also exhibit peculiar food habits, such as hoarding, sneaking or gorging food.

Early intervention is key to minimizing the long-term and permanent effects of abuse, neglect or multiple caregivers on a child's brain development. After the first several years of life, patterns of interaction with the world are formed, both psychologically and in the brain structure. These patterns become deeply ingrained and make it more difficult, although still possible, to improve a child's cognitive, emotional, and physical abilities.

Part of these difficulties are due to the fact that without consistent, positive nurturing, the limbic and cortex systems do not completely develop. The result is a neurological deficiency where behavior is regulated by survival and biological responses, and the child has little if any ability to regulate emotions, form attachments, and empathize with others. The child is emotionally stunted and, in severe cases, is physically underdeveloped.

A University of Wisconsin-Madison study of children adopted from Eastern European orphanages demonstrated that supportive and stimulating environments for infants and young children can lessen the adverse effects of prior negative environments. According to the study, the longer children lived with their adoptive families, the greater and continual the gains in attention, language skills, reasoning, sensory motor development, and reduction in attachment disorder symptoms (AACAP, 2000).

Supporting Parents of Children with RAD

Therapists should be nonjudgmental and supportive to parents who are lacking parenting skills or using parenting techniques that usually work well with typical children but are not effective when parenting a child dealing with an attachment disorder. The key is for therapists to encourage the parents' willingness to learn ways to be more responsive to and involved with their child.

With these parents, child therapy and relational therapy (parent-child) may be useful. Caregivers may struggle when disciplining

a child while trying to foster the child's ability to relate and trust. The therapist needs to provide the parents with a positively oriented and developmentally appropriate behavioral management program, avoiding punishments that are inappropriate or unsuitable for a child with RAD. One example would be for the therapist to explain that prolonged timeouts are not to be used, because to a RAD child timeouts can feel like abandonment.

One example of the effective use of timeouts for children with RAD is to explain to parents that timeouts begin with clearly setting ground rules for them with the child before confrontations occur. Timeouts are to be short, perhaps only two minutes depending on the child's age, and never to exceed 15 minutes. The goal is for every timeout to be structured the same, whether handled by a parent, caregiver, or school staff member (e.g., the same length of time, same location when possible, and same contact with the adult such as seated side by side holding hands or looking at a book during the timeout). The goal is to focus on the behavior, not the child. This is done with concrete language using the word *this* and excludes the word *you*: "This two minute timeout is because yelling is hard to hear." or "This two minute timeout is because hitting hurts."

Children with RAD often possess a skewed sense of the meanings of words such as *trust*, *friendship*, and *responsibility*. It's important for the parent or caregiver to repeatedly define these words in the context of concrete examples, so the child can actually experience the meaning of the word with this new definition. As a result, children can translate the meaning of the word into a skill they can practice with others. For example, the concepts of:

1. Trust can be illustrated through the comparison to the library trusting a child to return books on time and in good condition;
2. Friendship can be demonstrated by making a birthday card for a sibling or classmate;
3. Responsibility can explained as dishes go in the sink when you are through eating.

Note that in the last example, the word *you* is used in a direct connection

of the child and the child's behavior. This connection allows the child to begin changing his or her sense of identity and awareness of self-worth.

In parenting support groups, it also can be useful to explain to parents of children with RAD the importance of helping the child build new perceptions of adults as people who can be trusted and dependable. For example, stealing or hoarding food is common among children with RAD. Confronting this behavior can provide the current caregiver an opportunity to ask, "Can you trust me that I will prepare your dinner for you in one hour?" If the child says no, the parent can say, "I can understand how trusting is hard for you because your dad didn't give you dinner every night. You had to find your own meal. Can you sit with me for five minutes and trust me that in five minutes I will prepare you a snack while we wait one hour for dinner?"

Play therapy can also help parents learn how to let the child initiate play activity, select toys, or direct an art project. In working with adolescents, board games such as Life and Clue are useful in helping teens master frustration, tolerance, and self-control while also improving socialization skills. The teen's reaction to winning or losing, and their occasional attempts to change the rules (or even cheat) all are matters for therapeutic discussion (Webb, 1991).

Narrative therapy is useful with older children who are verbal, as the therapist can organize the experience into discussions illustrating cause and effect relationships. This approach helps older children verbalize feelings, distinguish between past and present, and build a sense of distance from the experience. Being able to think, rather than act, strengthens self-control.

Treatment Methods for RAD

Some treatments of RAD have been controversial. One recent method, called *attachment, holding or in-arms therapy*, maintain children suffering from RAD have no moral foundation and no empathy or remorse. They also lack the ability to give and receive love, lack cause and effect thinking, and may lack appropriate levels of self-control (yet are superficially charming and engaging). As

such, traditional therapies – talk therapy and behavior modification—are ineffective with these children. Before they can learn to trust and bond with primary caregivers, attachment holding proponents believe children with RAD must be emptied of the rage they feel for caregivers that abandoned or abused them. Holding therapy can range from a mother rocking a child in her arms with forced eye contact to “rebirthing,” a forced simulation of the birth process in which the child is wrapped in blankets. A typical holding involves the therapist provoking the child into a rage. Then the therapist holds the child, possibly pinning the child’s arms back, to take away control. Advocates believe holding therapy encourages the child to go back in time and experience distress and anger while a loving adult remains in control.

However, the American Academy of Child & Adolescent Psychiatrists (AACAP) (2002) reports in a position statement on RAD that “There is no scientific evidence to support the effectiveness of such interventions” and adds that at least six documented child fatalities have occurred in the use of holding therapy. These deaths created a negative awareness of the therapy, which has since been forbidden in Massachusetts, New York, New Jersey, Pennsylvania, Texas and Utah.

The AACAP statement continues, “Children who exhibit signs of Reactive Attachment Disorder need a comprehensive psychiatric assessment and individualized treatment plan. Treatment of this complex disorder involves both the child and the family. *Without treatment, this condition can permanently affect a child’s social and emotional development*” (emphasis added by author) (2002a, p. 1).

Pediatricians, social workers, and day care workers must be alert for evidence of neglectful parenting among infants and preschoolers, as early intervention, close coordination of services, and follow-up care are key to successful treatment outcomes. Once a parent is identified as being at high risk for neglect, parenting classes should be made available. Either a social worker or doctor should monitor and support the parent to insure the child’s needs are being met.

As infancy and early ages can be the most fragile stages of child development, every effort should be made to either maintain

children in their homes with social services support or to place them in a kinship community setting (as long as the child's safety can be assured). Placement with a relative provides the child the advantage of knowing his or her biologic roots and family identity. Whether the child's placement is in foster or kinship care, the key for a positive placement involving a child with RAD is a consistent, responsive caregiver.

Parents or caregivers of children with RAD must be prepared to spend a large amount of time and energy in learning and practicing supportive, nurturing, consistent, and limit-setting parenting techniques. One of the most complete resources for understanding attachment disorders is Siegel and Hartzell's *Parenting From the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children Who Thrive* (2003). The book explains:

1. How a typical brain develops from birth through adulthood.
2. How a traumatic event affects a child's brain development and the child's ability to form attachments.
3. Examples of positive interventions parents, caregivers and therapists can use to help a child repair current relationships and build positive new ones.
4. How these interventions can help people of any age learn to deal with their attachment issues and connect more effectively with others.

Treating Severe Cases of RAD

As children with RAD can be hyperactive, depressed, and even suicidal, it may be necessary to manage these symptoms with medication but always in combination with therapy. Options may include stimulants, anti-depressants, and mood stabilizers, but there are no medications specifically developed for RAD.

For children experiencing severe RAD, hospitalization may be necessary, especially when medical care is unable to establish clinical stability. If the hospital program is experienced with RAD, this treatment setting can enable the most thorough evaluation of both the child and the home environment. It also can maximize the opportunity

for non-medication based interventions, (e.g., supportive limit setting and parent education). Hospital settings may enable coordination of social service support options and special education interventions. Once a child with RAD is stabilized and responding well to treatment, the next treatment step can be partial hospitalization.

Summary

In conclusion, RAD is one of the most complex and most misunderstood childhood psychiatric disorders. Early intervention and in-depth evaluation of both the child and home environment are vital for the best treatment outcomes. Parents and caregivers should be extremely diligent in interviewing potential treatment sources for their child. Treatment providers—whether child and adolescent psychiatrists, psychologists, pediatricians, or therapists—should be forthcoming in detailing their experience with the disorder and facilitate a connection to the most experienced treatment provider available.

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