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Daniel F. Shreeve

Reactive Attachment Disorder

A Case-Based Approach

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Daniel F. Shreeve
The Carilion Clinic
Rehab Building
2017 South Jefferson Street
Roanoke, VA 24014, USA
danlshreeve@yahoo.fr

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Chapter 1
Introduction

Format of the Exercise

This exercise introduces the clinician to reactive attachment disorder (RAD), a childhood disorder involving a general failure of social relationship caused by early, grossly pathogenic care. In order to begin a study of such fundamental impediment to attachment in earliest life, we must as students of child psychiatry define what we mean by "attachment" and also must consider how we will prove a relationship to emotional neglect. A brief introduction to the process of normal, early childhood attachment is essential, before turning to the definition of abnormal attachment and to the topics of differential diagnosis and comorbidity.

Our representative case of "Jorge" is presented as unfolding over time and structured to illustrate challenges of diagnosis to show examples of overlapping syndromes and to promote reflection on what questions may arise during treatment. Within the case presentation are additional, brief segments – identified as "case points" – which bring in topics related to treatment of RAD so as to add a degree of dimensional realism to the illustration of clinical method. An initial set of test questions follows the case presentation, to enliven the exercise.

A review of the etiology of RAD is necessarily broad and interdisciplinary. Adhering to the biopsychosocial model, the section on etiology will cover current theories divided into "biological basis," "psychological factors," and "social origins." Sections which follow the case presentation serve to illustrate, within limits of space available, the directions of advancing research. One example of the unknown, for instance, is how the experience of deprivation at critical stages leads to RAD for some children, whereas others overcome even severe disadvantage. A related, and equally unanswered question, is whether our definition of secure attachment as "normal" actually matches with the history of our species, a history characterized by rare periods of peace and frequent episodes of violence or extreme adversity. Recent work on the adaptive advantage of a range of attachment types is presented, as a prelude to further questions about "what we are treating."

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We return to the topic of the principal role of the psychiatry clinician within an interdisciplinary system of care, in the final sections on treatment of RAD. Many methods of therapy have been applied to this difficult disorder, and the summary is necessarily brief. The section on psychotherapy follows conventional psychiatry categorization into evidence-based treatments, those with professional consensus, and those without evidence which may do harm. A second test on general principals follows, and there is an explanation of answers at the end of the text.

By completing this exercise the interested learner should be able to:

1. Define attachment behavior in terms of early mother–infant interaction and explain the evolutionary significance of attachment in the species, as well as relate disorders of attachment to psychopathology
2. Define reactive attachment disorder (RAD) including subtypes, with explanation of the origin and what is generally known about longitudinal course
3. Define the subtypes of attachment as characterized by Ainsworth and others, and compare these to RAD
4. Explain major theories of the etiology of RAD and relate them to the explanations for human diversity in the types of attachment
5. Recognize common comorbidity of RAD and envision how to participate as a psychiatrist on an interdisciplinary treatment team with a real case

What Is Attachment?

Attachment is so familiar to most of us – so basic to social life – that we may rarely perceive it to be an option. When one reflects on one's own relationships, past or present, attachment cannot be defined as something fixed or immutable. Even for close bonds, the sense of attachment recedes one day, and advances the next. Strictly speaking, attachment is also not equivalent to attachment behavior [1]. The presence of danger, for example, provokes attachment behavior, but when the environment is constant the attached ones – child or adult – may draw apart physically or emotionally for a time, perhaps to verify independence, or to gauge the degree of intimacy. Thus attachment itself is a predisposition rather than a behavior. It derives as an accretion of shared moments, such that new events are interpreted in the context of past co-experience. Even when apart, a mental conversation may continue, or the story of a separate adventure is prepared for telling.

We may thus adopt a working definition of attachment as a selective interest in an individual with whom we share new experience with implicit reference to the past together, and whom we will miss if unable to communicate about our responses to something new. Perhaps attachment is best understood in emotional terms when it is interrupted, as we experience distress or longing for the missing loved one. This makes reactive attachment disorder (RAD) all the more difficult to accept in a child, since we would expect a normal dependency on adult figures, related to the need for relatively greater protection in early life. We therefore turn next to the definition of original authors of attachment theory, whose writings comprise the basis for understanding RAD and its treatment.

The Place of Attachment in Nature

An exploration of emerging new theories for RAD may best follow our approach to an example that illustrates the approach to a real case. To assess psychopathology, however, we need a model of normal attachment, and we will review a developmental model of normalcy, which has guided clinicians and families, both at the stage of assessment and in treatment.

Often referred to as "the father of attachment theory," John Bowlby [2] considered both humans and other primates and the conditions of survival. While a psychoanalyst by training, Bowlby embraced the important advances of ethology of his time and sought to apply this natural science, founded in evolutionary theory, to the science of human attachment. Attachment behavior, from an ethological perspective, is any action of infant or mother that promotes proximity, the essential condition for human safety in the wild. As summarized by Main [3], the infant separated from his attachment figure(s) will usually lose food, water, warmth, shelter, and protection from predators.

Bowlby [2] defined stages of attachment for the mother–infant dyad, beginning with the first 3-month period of indiscriminate orientation response to the proximate sources of comfort. In the next several months, the infant recognizes and develops a preference for one or more familiar caregivers. An important influence on the next stage – from late in the first year through the third year – is the growing ability to ambulate. This gives the child some control over proximity, and conversely there is an advancing capacity to explore the surround, using the mother as a "secure home base." Mothers, as part of the "attachment system" favored by evolution, closely monitor the toddler's advances in independence, as well as state of need, especially need for rescue in times of distress. For this stage, theory of natural selection predicts that fitness of the child increases with appropriate balance of safety and exploration, whereas biological fitness of the parent increases in proportion to sensitivity to the infant's immediate state of need.

The following stage, as recounted by Bowlby, involves the child's growing awareness of the mother's mood and direction of interest, such that a "directed partnership" emerges. A mutual sensitivity to signals and familiarity with the pattern of reciprocal responses yields a certain familiarity in this earliest example of human relationship. A biologically coded capacity for attachment is shaped by particular shared experiences of parent and child.

Building upon Bowlby's theory of attachment, Ainsworth and her colleagues developed a typology for attachment in childhood [4]. Ainsworth and Bell [1] theorize that the purpose of prolonged infancy in our species – and the adaptive value – relates to the human capacity to explore, and the importance of an extended supervision of the exploratory phase "a prolonged infancy would miss its adaptive mark if there were not also provisions in the genetic code which lead the infant go be interested in the novel features of his environment – to venture forth, to explore, and to learn." Of equal value to proximity-seeking is thus the exploratory urge, involving also the parent's flexible appraisal of progressive independence; "at first infant and mother are in almost continuous close contact, soon they are in collusion to make more elastic bonds that unite them."

Ainsworth is perhaps best known for her design of a laboratory test that defines types of attachment, beginning with the primary divide between secure and insecure types of attachment. The Ainsworth test for child attachment type – the Strange Situation – is a structured sequence of separations from and reunions with the caregiver (with and without the examiner present). Imbedded in this sequence are the critical reunion episodes, which reveal the nature of the mother–child attachment. A securely attached toddler will freely explore the environment when their mother is present, shows moderate distress at separation, and then will show immediate, obvious joy on reunion. Insecure toddlers in contrast delay their greeting of the returning parent, turn and move away, or even show tantrums when the mother returns to the room. A further subtype of disorganized attachment reveals itself at reunion in a mixture of approach and withdrawal responses, contradictory emotions of high intensity include expressions of neediness, aversion, and angry resentment [5].

In the middle-class American population studied by Ainsworth and her colleagues, secure attachment had the highest frequency, around 60% of the sample. As regards the pathological significance of insecure attachment, Ainsworth did not rush to conclusions. For example, she did not claim (contrary to some viewpoints) that insecure attachment is a direct function of parenting errors. Nor does Ainsworth propose a direct relationship between difficult temperament and disorganized attachment. Perhaps because of this careful science, the Ainsworth typology and the Strange Situation test itself remain useful in ongoing empiric research on attachment behavior in young children, and have been applied to the study of RAD. It is important to note however that RAD is not a subtype of attachment nor part of the Ainsworth typology; it is more accurately defined by relative absence of selective proximity seeking. For clinical purposes, a chief complaint or primary problem in RAD is the impairment in selective, progressive, and exclusive relationship.

The Process of Attachment in Early Childhood

Two events during infancy life, related to our subject of attachment, have critical effects through the lifespan: emergence of a sense of self and the growth of a capacity to regulate emotions. Mahler's seminal work on separation-individuation in early childhood [6] proposes a series of stages in the construction of the self: from earliest infancy an "autistic" self-absorption transitions to a stage of symbiotic merger, or oneness with the mother. The stage of "hatching," at around 5–9 months is the earliest point of separation-individuation, following which, during the "practicing" stage (9–16 months) the child practices independent actions always relying for potential rescue, or emotional reassurance from the parent figure while advancing the zone of independent enterprise. Practice in independent exploration supports individuation, whereas availability of the parent figure allows for an internalization of a model for resolution of distress. Reliability of the parent figure in the face of emotional storms also reinforces a belief in the "other" as a constant, dependable, and separate

individual. Mahler's concept of "the psychological birth of the human infant" thus entails a dawning awareness both for self and for "other," each as a differentiated individual and hence ready to interact.

Countless episodes of separation and reunion lead up to a stage of "rapprochement," the point at which – roughly 16 months and older – the infant must reconcile the urge for independence with a growing awareness of the risks of separation. Adventuring away from the parent figure seems to lose its quality of pure adventure and celebration, and may even involve the infant in an appearance of sadness, which may concern the parent [7]. Yet this more conscious comprehension of individuation comprises the essential model for "relationship"; the dyadic relation now involves self, other, and their variable transactions. With the recognition of separateness comes fear of abandonment and a sense of loss of the earlier state of union with the loved one. Success in the infant's struggle for separation-individuation requires the internalization of a model of self and a model of others as authentically separate. As defined by Mahler, object constancy – achieved in the third year – is a "capacity to recognize and tolerate loving and hostile feelings toward the same object; the capacity to keep feelings centered on a specific object; and the capacity to value an object for attributes other than its function of satisfying needs." The conceptualization of self and other is the platform for a real attachment model for subsequent relationship beyond the dyad.

Certain qualities in the caregiver may be crucial to successful individuation. As defined by Winnicott [8] the "good enough parent" is one who is empathic toward the infant and available to assist the child's moment-to-moment, purposeful actions. An example of such "facilitated gesture" might, for example, start with the parent attending to their child's effort to reach for a toy which is too high up, and then their own action to bring the object just into reach. Opposite to this is Winnicott's "substituted gesture," an action by the parent that interferes with the purpose of the child, as driven by the parent's own, and separate aims. An example could be the parent who persistently urges a child to sustain an activity or theme when they are clearly fatigued, or when they have shifted to a new interest. Winnicott depicts the "good enough parent" as providing the "holding environment," within which the child can advance to a definition of self. But, with potential relevance to RAD, in the absence of empathic parenting the child may strive to conform to the adults "substituted gesture." The child's accommodation to adult substitution of motive can give rise to a false self [8]. A possible application to RAD is an appearance of "pseudomaturity," defined as a show of self-sufficiency which seems to eliminate the need for parental help or intervention [9].

Equally pivotal to our understanding of our first attachment is the concept of attunement described by Stern [10], according to which the parent identifies with the child's immediate state of emotions, such that the reciprocal responses of parent and child transpire with emotions implicitly shared in the moment. Attunement is an identification with the emotional state of the other, which recognizes and validates a co-experience of the moment and, through this sharing, reinforces the centrality of the dyadic relationship. Attunement also vitalizes and energizes the dyad, producing

a kind of dynamic force which energizes the engagement of parent and child [11]. Tronick [12] proposes that in secure attachment there is dynamic harmony of affect and intention, a kind of interactive synchrony. During a phase of alert engagement, the interaction of mothers with their infants has been likened to a dance, in which affective signals and moves of the dance are sequential, reciprocal, and contingent such that they manifest a harmony of emotion and intention [13–15]. Critical to secure attachment and the child's self-esteem is thus infant–mother coordination of communication in the moment, and the capacity for "affective reparation" [16].

Emotional self-regulation can be viewed as a related theme of development, which depends upon security of attachment. In marching toward greater proficiency in independent behavior, the growing child must master reflexive, potentially excessive emotional response to frustration in order to favor reflexive, more advanced cognitive and communicative strategies. Whereas the infant internalizes an image of a rescuing parent at moments of distress, the toddler will hopefully have an inner model of this rescue which fosters self-soothing, which in turn allows for a pause to consider a range of options (which might however involve calling out for the parent). In a review of emotion regulation, Cassidy and Berlin [17] illustrate that the empathic parent provides for, not only a soothing and dampening down of negative emotion, but also direct encouragement of positive affective states. Thus, in addition to their role in unconscious attunement to the child's affect, parents consciously correct and socialize the child's response to frustration, generally by providing examples and explicit advice.

To further clarify the role of attachment in emotion regulation, reference should be made to the psychological principle of "scaffolding," a term coined by Vygotsky [18]. According to this principal, an available and caring adult interprets the child's interest and capacity, and with this reference in mind will aid the child in advancing to a new level, either in learning a task or with a method of coping with challenge. We may conclude that "good enough" attachment works at the child's "proximal zone of development," and involves both a shared emotional and shared cognitive frame of reference in an ongoing, dynamic process which is normally strengthened by ties of affection.

Definition of Reactive Attachment Disorder (RAD)

According to DSM-IV the essential feature of RAD is marked disturbance of social relatedness in most contexts that begins before age 5, and which is preceded by grossly pathogenic care [19]. Children with RAD may present in two quite different, even opposite-appearing subtypes: those who withdraw from interpersonal encounter, RAD inhibited-withdrawn type; and the RAD disinhibited-indiscriminate type, those who show little reserve toward strangers and seem impulsive as well as nonselective in the pattern of relationship. Key to both types of attachment disorder is absence of selective proximity-seeking: the child does not go to the familiar caregiver in time of distress and, thus, does not appear to use this person as

a safe "home base" from which to explore outward. Children with the disinhibited form may literally meet strangers with open arms, thus appearing to devalue the special relationship with a parent figure (and often worrying them on the matter of safety in public). In contrast, children with the withdrawn, inhibited subtype are reluctant to engage with their parent figure, or they might comply mechanically and without feeling. Reunions after time apart may be emotionally charged but ambivalent; the child pulls away or avoids eye contact, which may shake the caregiver's faith in the possibility for growth in the fragile, nascent attachment.

Differential Diagnosis

The historic pattern of symptoms is critical in distinguishing RAD from other childhood disorders, including childhood post-traumatic stress disorder (PTSD) and autism spectrum disorders (ASD). The criterion of severe pathological neglect for RAD seems clear enough; however, we face a practical problem when – as often occurs – records are lost in a transfer between the time of removal from the original home and a foster placement. Can the effects of the early environment be surmised from impressions of case managers who have only recently taken up the case? The child's own history is necessarily limited: pathogenic care will often have occurred prior to their use of words to describe the environment or their responses to it. Frequent shifts of many children with RAD in the foster care system paradoxically shifts the responsibility for history onto the new adult caregivers, even when they have only brief acquaintance with the child [20]. Reliability of diagnosis can, of course be improved by direct observation of the children interacting with their caregivers. Clinical scales may also usefully supplement the child psychiatry assessment and can help direct investigation of identified problem areas [21].

In the real-time clinic interview, children with the inhibited withdrawn form of RAD may resemble children with ASD in level of emotional detachment, and lack of reciprocity. Rutter et al. [22] studied children with early, severe deprivation and described "quasi-autistic features" which included lack of social awareness and lack of observance of personal boundaries. Both types of RAD however separate from ASD in the longitudinal pattern course of symptoms. RAD children may show social inhibition, but eventually are congruent and reciprocal in the use of nonverbal and verbal communication with their parent figure. Other signs of ASD such as repetitive stereotyped behavior and restricted range of interest are also absent in RAD. Language delay is commonly present in RAD at time of placement removal from an adverse setting, but progressively improves, unlike the case of ASD. Children with RAD do not demonstrate the idiosyncratic language of ASD, such as echolalia or pronoun reversal.

Because of the effect of early childhood maltreatment on language, the diagnosis of mixed receptive-expressive language delay must also be distinguished from RAD based on symptom course. In RAD, language including its pragmatic elements is available as "equipment" for attachment, yet is not applied normally to enhance a

selective interpersonal bond. Verbal expression of emotion may lag behind the generally positive course for language development in children removed from adverse environments (see section Alexithymia to follow).

Given the impact of gross pathogenic care in early childhood, it is often difficult to distinguish symptoms of RAD from those of PTSD. A practical question is whether the clinician can reasonably differentiate post-traumatic symptoms from those of attachment disorder. Hyper-arousal and hyper-vigilance could certainly compromise the capacity for trust in attachment for children with PTSD. A distinguishing feature of RAD is, however, the worsening of behavioral symptoms as familiarity increases with the new caregivers, as if progressive intimacy presented a new stress, rather than a reassurance. Though not a formal diagnostic criterion, this tendency to worsen under conditions of environmental constancy can be a "hard sign" for RAD. The child's history – when reliably obtained – is the most determining of diagnosis: in PTSD there is one or more instances of trauma which produce symptoms, whereas for RAD there is early deprivation followed by impairment in progressive attachment to the parent figures, as well as by general impairment in social relations.

Comorbidity

Franc et al. [23] have recently reviewed similarities of RAD with a more common disorder of childhood, attention deficit hyperactivity disorder (ADHD). Although, RAD is rare in comparison to ADHD, there is overlap for some children in the domain of emotional self-regulation – the ability to self-soothe and to organize responses to adverse or challenging stimuli. Intemperate, strongly negative emotional displays often occur in both disorders, sometimes culminating in a trend to oppositional-defiant, disruptive behavior. Conversely, Franc et al. suggest that secure attachment might protect against development of ADHD by promoting cognitive and emotional organization.

Hall and Geher [24] have examined behavioral and personality characteristics of children with RAD. On a broad-range standard symptom inventory, the Child Behavior Checklist [25], children with RAD show both externalizing and internalizing symptoms, including anxiety/depression, thought problems, social problems, and aggressive and delinquent behavior. On other tests, affected children scored low on measures of empathy, and tended to minimize negative personality traits, or to represent them in overly positive ways.

Appropriate assessment of RAD will require multiple encounters, including observations of how the child interacts with familiar caregivers. At the time of initial interview, common comorbid conditions should be considered and identified, including oppositional-defiant symptoms and school adjustment problems [26]. Commercially available surveys which purport to adequately diagnose RAD based upon a composite of comorbidity lack specificity, because of the variability of symptoms within the diagnosis [27]. Routine standard child symptom inventories

are recommended instead, for the purpose of identifying comorbidity as well as for prioritizing those interventions which the psychiatrist can provide as a member of the treatment team. Separate forms are available for school-age [25] and for pre-school children [28]. The psychiatrist should be prepared for additional diagnostic assessment of syndromes suggested by the symptom inventory, and for treatment of comorbid conditions including mood and anxiety disorders, PTSD, ADHD, and ODD.

Chapter 2
Vignette of "Jorge"

(A Representative Case for Study)

Part 1: Jorge as a Toddler

Ted and Beth were childless and in their late 30s when they decided to adopt. Beth had postponed pregnancy, determined to earn an advanced degree in linguistics, to build her academic career in foreign languages, and to extend her networking possibilities as a translator. Ted transitioned to a job as an athletics coach after achieving his bachelor's in English literature, not his original aspiration, but rewarding enough in his early career. With local downsizing of the public school, he was compelled to search for new opportunity and eventually landed a job with a landscaping firm. Recently business was slow, but at least the family would not have to move. Over 10 years of marriage without dependents, Ted and Beth were financially secure with their combined salaries and were comfortable with the monthly bills. The Smiths were also happy as a couple, though Beth was aware of Ted's wish for a child and his effort at "not bringing up the subject." Generally they handled the subject with the unwritten rule of "avoiding the subject" or at least maintaining a courteous consideration of each other's feelings. They often reflected that they were lucky as a couple, sharing, for example, their enjoyment of a rural town and many of the same friends from childhood.

Family life changed after the death of Beth's mother, and Ted became consoler and silent support in a winter of extended grieving, during which Beth appeared to lose interest in meeting friends, or even getting out for a walk. Despite the intimacy of a shared or similar experience, their relationship was marked by unaccustomed, minor squabbles, and "arguments over nothing." Beth shared her disappointment in her family of origin; her father and brothers were even more reserved and actually shifted away emotionally despite sharing a loss. It seemed as if with the loss of her mother the family had also lost its center.

Beth and Ted strengthened ties with their church during this period and, possibly influenced by the sight of families with young children, or their new friends, they began to share the idea of a child late in life. Eventually they considered this carefully, even to the extent of meeting with a financial counselor who seemed

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