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Understanding Reactive Attachment Disorder in Children

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Abstract

Reactive Attachment Disorder (RAD) is recently new to clinical literature. RAD is a “Stress and Trauma-Related Disorder” that stems from an inability for a child to attach to a caregiver. Aside from some psychoanalytic foundations, most of what is known about RAD is based off John Bowlby’s attachment theory. As research has developed, RAD has been considered its own diagnosis in the DSM-5 rather than labelled under the umbrella term of “attachment disorder.” A biopsychosocial model of RAD argues that RAD is primarily formed and exacerbated by neglect from a caregiver that can infringe upon the child’s ability to form relationships later in life. Being a new diagnosis, current and detailed prevalence and prognosis of RAD are unknown. In addition, legal implications of maltreatment further contribute to the under-diagnosis of RAD. Currently, holding therapy is the most prominent treatment for RAD. Because so little information is known about RAD, more study and experimentation is necessary for better treatment and understanding.

Understanding Reactive Attachment Disorder in Children

Reactive attachment disorder (RAD) is a recently identified disorder that is included in the DSM-5 category of “Stress and Trauma-Related Disorders” (American Psychiatric Association, 2013; Lehmann, Breivik, Heiervang, Havik, & Havik, 2016). RAD is commonly diagnosed in children and involves an inability to create attachments with a caregiver at an early age, which may impair the formation of relationships at a later age (Mizuno et al., 2015). Although understudied because of its recent entry into the DSM 5 (Shi, 2014), I will argue that RAD is a difficult-to-treat disorder.

Theory and Evolution of RAD

Before the mid-20th century, aside from Freudian psychoanalysts, not much attention had been given to psychological disorders in young children, especially attachment disorders. John Bowlby, a prominent child psychiatrist, became a pioneer in the study of such disorders (Follan & McNamara, 2014). Bowlby (1969) theorized that attachment is crucial in the development of an infant’s ability to socialize and self-regulate (Vasquez & Stensland, 2016). The infant creates attachment with a biological parent—usually the mother—to enhance comfort and survival (Mikic & Terradas, 2014). Like Bowlby, Shi (2014) argued that maladaptive behaviors in childhood and continuing on to adulthood may result from failed attachment. With this perspective, many psychologists now approach the etiology and treatment of RAD using Bowlby’s perspective.

RAD was not specifically categorized and distinguished from other disorders until the DSM-5 appeared. General symptoms were first listed in the DSM-III, based on the literature of deprived and institutionalized children (Mikic & Terradas, 2014). The idea of an attachment disorder was introduced in the DSM-IV-TR in 1994 (Vasquez & Stensland, 2014). It was separated into two subtypes: (a) emotional detachment from caregivers or the inhibited type and (b) indiscriminate towards caregivers or the disinhibited type. New criteria for the diagnosis of attachment disorder were introduced in 2000 as part of the Bucharest Early Intervention Project (BEIP), which was a study of foster care as an intervention for abandoned children in Romania. In the DSM-5 attachment disorder is described as two

separate disorders based on the DSM-IV-TR's subtypes: (1) reactive attachment disorder (inhibited type) and (2) disinhibited social engagement disorder (disinhibited type; Lehmann et al., 2016; Mizuno et al., 2015).

Criteria for attachment disorder in the DSM-IV-TR included exposure of the infant to pathogenic caregiving, such as the disregard of emotional needs and basic needs, as well as caregiver turnover (Mikic & Terradas, 2014; Vasquez & Stensland, 2014). Also, the onset of the disorder must be evident before age five (Shi, 2014). To further clarify RAD as its own diagnosis, more criteria were added in the DSM5, namely, that the child has reached a developmental age of at least 9 months and that criteria for autism spectrum disorder are not met.

Currently, the characteristics and implications of RAD in older children and adults are unknown (Mizuno et al., 2015). One of the largest issues is the prevalence of RAD in the adolescent and adult population. In fact, the prevalence of RAD in children remains unknown (Mayo Clinic Staff, 2017; Minnis et al., 2013). Because one of the criteria for the diagnosis of RAD is neglectful or abusive caregiving, reports of RAD are not likely to be reported to psychologists or other healthcare professionals. Given the existing legal penalties for maltreatment of children, RAD remains a disorder that is understudied and underreported and, therefore, undertreated (Mizuno et al., 2015).

A Biopsychosocial Model of RAD

Like many other psychological disorders, the etiology of RAD is influenced by biological, psychological, and social factors. Only limited research has been done on the biological basis of RAD, but there is much research on psychological and social influences.

Biological Factors

Shi (2014) stated that human beings are biologically driven to seek and maintain proximity, that is, to become attached to others. Mizuno and colleagues (2015) argued that these attachments lead to the creation of new neural connections in the brain. Thus, as a child ages, the brain networks are influenced by his or her attachments or the lack thereof (Vasquez & Stensland, 2016). Zeanah, Chesher, and Boris

(2016) also found that children diagnosed with RAD have difficulties with the regulation of their amygdala—the emotional control center of the brain.

Psychological and Social Factors

As previously indicated, most mental-health professionals accepted the etiology of RAD proposed by Bowlby (Follan & McNamara, 2014). With the help of caregivers, the infant learns meaning and begins to understand the world. When caregiving relationships do not develop or caregivers negatively affect the infant through neglect or abuse, the child may perceive the world as unsafe and dangerous and view herself or himself as unloved or unimportant (Vasquez & Stensland, 2016).

The Treatment of RAD

Because RAD is a new clinical disorder most of the research on its treatment has focused on psychological and social factors that are identified in Bowlby's attachment theory (Buckner, Lopez, Dunkel, & Joiner, 2008; Shi, 2014). Attachment therapies, like holding therapy, have been the most utilized for treatment of RAD.

Attachment Therapy

Attachment therapy is used for a diversity of disorders (Shi, 2014). For RAD, the focus of attachment therapy is fixing the central problem—creating and enhancing attachments between children and their caregivers. The therapist works with the caregiver and the child to establish a relationship and may focus on changing the perspective of the child as unloved by teaching the caregiver to be more affectionate and attentive to the child. Because the incidence of RAD is unknown, relapse rates are only estimated (Vasquez & Stensland, 2016).

Holding Therapy

The most publicized form of attachment therapy for children is holding therapy (Buckner et al., 2008). Its focus is to remove the aversion to “noxious stimuli” (p. 290), such as tickling or poking and restraint. According to Bowlby, healthy attachment is achieved when the child's aversion to noxious stimuli is extinguished by graded exposure to the stimuli while the caregiver holds the child. Currently, no research or statistics are available for the effectiveness or relapse of

patients who participate in holding therapy, especially with the legal implications of maltreatment for infants (Vasquez & Stensland, 2016; Buckner et al., 2008, p. 290).

Conclusion

RAD is new to the clinical literature, and thus there is a need for more research in order to improve understanding and treatment. To date, the biopsychosocial model for RAD is primarily based off John Bowlby's attachment theory, which posits that the relationship between infant and primary caregiver is essential for the infant's formation of social relationships in adulthood and self-regulation. When the infant is exposed to negative treatment such as neglect or abuse, a child is unable to form attachments. These attachments—or lack thereof—create specific and influential neural connections that influence emotional behavior. Bowlby's attachment theory is focused on interactions between child and caregiver. Psychotherapy is the most widely used treatment for RAD. Specifically, attachment therapy, like holding therapy, brings an emphasis on neutralizing the trauma that resulted from the child's exposure to the caregiver. RAD is characteristically difficult to treat because improvement is dependent on the relationship between child and caregiver, a relationship that may be resistant to modification.

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