ATTACHMENT

Reactive Attachment Disorder
Attachment Problems
Trauma

2012
Development of Attachment

- Preferred attachment starts about 6-9 months of age
  - Stranger wariness
  - Separation protest
  - In our culture small number of adult caretakers
  - Hierarchy of preference
Development of Attachment

- Types of Attachment* seen by 12 months
  - Secure
  - Avoidant
  - Resistant
  - Disorganized

- Relationship specific, not a “child-trait”

- Need to differentiate between attachment and social behaviors

- Clinical and research conceptualizations of insecure attachment and RAD are not synonymous.

*Strange Situation Procedure
Development of Attachment

- Insecure attachment (avoidant or resistant) is not a diagnosis or indicator of psychopathology but a risk factor.
- Disorganized attachment has a stronger link to psychopathology.
- Disorganized attachment is not equated to Reactive Attachment Disorder but it may be one of many psychiatric symptoms/diagnoses that can develop.
Reactive Attachment Disorder – DSM-IV

- Not a well-researched diagnosis – 1st appeared in DSM-III

- Results from inadequate caregiving; AND

- Encompasses two clinical patterns
  - Emotionally withdrawn inhibited type
  - Indiscriminately social/disinhibited type
Reactive Attachment Disorder – The Diagnosis

- Marked disturbance in social relatedness as evidenced by
  - Persistent failure to initiate or respond to most social interactions as manifest by inhibitions, hypervigilance or ambivalence (inhibited type)
  - Diffuse attachments as shown by indiscriminate sociability with inability to exhibit selective attachments (disinhibited)
  - Before 5 years of age, pathogenic care (disregard of emotional needs, physical needs or repeated changes in caretakers)
ISSUES

- RAD is rare, only a minority of children with severe caretaking deficiencies or abnormalities develop RAD

- Begins prior to the age of 5 years

- Limited research with contradictory findings
Alternative Criteria Sets

- DC:0-3R Deprivation/Maltreatment Disorder
  - Context of severe and persistent parental neglect or abuse or limited opportunities to form selective attachments
  - Emotionally Withdrawn/Inhibited Pattern
    - Rarely or minimally seeks comfort in distress
    - Responds minimally to comfort offered to alleviate distress
    - Limited positive affect and excessive levels of irritability, sadness or fear
    - Reduced or absent social and emotional reciprocity
DC0-3R continued

• Indiscriminate or disinhibited pattern
  ○ Overly familiar behavior and reduced or absent reticence around unfamiliar adults
  ○ Failure, even in unfamiliar settings, to check back with adult caregivers after venturing away
  ○ Willingness to go off with an unfamiliar adult with minimal or no hesitation

• Mixed Deprivation/Maltreatment Disorder

• Rule Out PDD

• Associated features: Failure to Thrive or other growth disturbances
RESEARCH DIAGNOSTIC CRITERIA – PRESCHOOL AGE (RDC–PA)

- Same criteria as DC-03R except
- The criterion for pathogenic care was eliminated because an emphasis on pathogenic care too narrowly focuses on maltreatment syndromes
- RAD describes the behavior of young children in the first 4 or 5 years of life. It is not clear what (if any) behaviors or symptoms constitute attachment disorders in middle childhood, adolescence or adulthood.

Supported by AACAP Work Group on Research
Alternative Criteria

- Alternative classification criteria led to substantially greater inter-rater agreement compared to DSM-IV.

- DSM-IV and proposed 5 criteria are broad and do not focus solely on attachment.

- Alternative criteria focus only on attachment.
Research Using Other Criteria

- Inhibited type
  - Placed in supportive environments, symptoms remit

- Indiscriminate type
  - Length in poor care positively correlated with symptoms
RAD and Caretaker Attachment

- Strange Situation Procedure
- No attachment >>>inhibited
- Moderate negative correlation between secure attachment and indiscriminant
- However also find a high number of children with secure attachment with indiscriminant behavior
Stability of Signs - Inhibited

- Only one study on inhibited RAD
  - Moderately stable from average of 22 months to 54 months, those in institutional care more stable symptoms than for those in foster care
Stability of Signs - Indiscriminate

- Hodges and Tizzard, 1989
  - Comparison from age 4 to age 16 years
  - Stability in “over-friendly” and attention seeking behavior
  - Not as evident with caretaker, more so with peers (conflicted and superficial)
- Other studies also show moderate stability up to the age of 11 years of age
- No studies have gone beyond age 54 months in looking at other functional impairments
Symptoms of RAD and Behavior

- No significant association between inhibited and any externalizing behavior problems
- No significant association between indiscriminate behavior and aggression
- Moderate association between indiscriminate and inattention/hyperactivity/impulse control
Research School Age Children

- Few studies, no standard for assessing security of attachment in middle childhood
- Recent studies of school age children identify inhibited RAD (Minnis et al), however measures have unknown relationship to measures of RAD in early childhood, no requirement for pathogenic care and often did not differentiate types in the results
- Studies have found more consistency with the disinhibited type in middle childhood
Two Disorders?

- Both address attachment behaviors
- Some connection with pathogenic care
- However disinhibited type, child may
  - Lack attachments
  - Have attachments
  - Have secure attachments
  - Is it attachment or social engagement?
Focus of Diagnosis

Absent or aberrant attachment
OR
Social impairment

Attachment issues can lead to social impairment
Social behaviors improve when placed in nurturing environment
Better validity of measures regarding attachment
Attachment is the primary clinical problem that impairs the child beyond interactions with the attachment figure = RAD

OR

Attachment is merely one of a number of developmental domains that is compromised related to some other psychopathology
A. A pattern of markedly disturbed and developmentally inappropriate attachment behaviors, evident before 5 years of age, in which the child rarely or minimally turns preferentially to a discriminated attachment figure for comfort, support, protection and nurturance. The disorder appears as a consistent pattern of inhibited, emotionally withdrawn behavior in which the child rarely or minimally directs attachment behaviors towards any adult caregivers, as manifest by both of the following:

1) Rarely or minimally seeks comfort when distressed.
2) Rarely or minimally responds to comfort offered when distressed.
DSM-5 Proposed Criteria

B. A persistent social and emotional disturbance characterized by at least 2 of the following:

1) Relative lack of social and emotional responsiveness to others.
2) Limited positive affect.
3) Episodes of unexplained irritability, sadness, or fearfulness which are evident during nonthreatening interactions with adult caregivers.
DSM-5 Proposed Criteria

C. Does not meet the criteria for Autistic Spectrum Disorder.

D. Pathogenic care as evidenced by at least one of the following:
   1) Persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection (i.e., neglect).
   2) Persistent disregard of the child’s basic physical needs.
   3) Repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care).
   4) Rearing in unusual settings such as institutions with high child/caregiver ratios that limit opportunities to form selective attachments.
DSM5 – Disinhibited Social Engagement Disorder

A. A pattern of behavior in which the child actively approaches and interacts with unfamiliar adults by exhibiting at least 2 of the following:
   1) Reduced or absent reticence to approach and interact with unfamiliar adults.
   2) Overly familiar behavior (verbal or physical violation of culturally sanctioned social boundaries).
   3) Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
   4) Willingness to go off with an unfamiliar adult with minimal or no hesitation.

B. The behavior in A. is not limited to impulsivity as in ADHD but includes socially disinhibited behavior.
DSM5 – Disinhibited Social Engagement Disorder

C. Pathogenic care as evidenced by at least one of the following:
   1) Persistent failure to meet the child’s basic emotional needs for comfort, stimulation, and affection (i.e., neglect)
   2) Persistent failure to provide for the child’s physical and psychological safety.
   3) Persistent harsh punishment or other types of grossly inept parenting.
   4) Repeated changes of primary caregiver that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
   5) Rearing in unusual settings that limit opportunities to form selective attachments (e.g., institutions with high child to caregiver ratios).
APSAC Task Force

- Cannot equate maltreatment with having RAD
- It should not be assumed that RAD underlies all or even most of the behavioral and emotional problems seen in foster children, adoptive children or children who are mistreated.
Course of RAD

- Not studied, normally discussed in terms of infants and preschoolers
- Inhibited RAD, majority when placed in caring environment, no longer have RAD
- Indiscriminant RAD, may continue even after placed in caring environment. May attach to caregiver but still have indiscriminant sociability. More likely to have poor peer relationships
- No validated measures for adolescents
Treatment

- For RAD or attachment disorders, treatment engages both the caretaker and the child because it is based on the development of the relationship.
- In response to the caregiver maltreatment, should either increase responsiveness and sensitivity of the caregiver or change the caregiver.
- It is NOT changing the child.
AACAP Practice Guidelines

- Assessment – evidence directly obtained from observations of the child interacting with caregiver and history of the child's patterns of attachment and care-giving environments

- A relatively structured observational paradigm should be conducted so can compare across relationships
AACAP Guidelines

- After assessment, report any previously unreported maltreatment.
- Maltreated children are at high risk for developmental delays, speech and language deficits/disorders and untreated medical conditions. Assess and refer as appropriate.
- For young children with RAD, most important intervention is for the clinician to advocate for providing the child with an emotionally available attachment figure.
AACAP Guidelines

- Assess the caregiver’s attitudes toward and perceptions about the child
- Children with RAD are presumed to have grossly disturbed internal models for relating to others. After ensuring the child is in a safe and stable placement, effective attachment treatment must focus on creating positive interactions with caregivers. In order of preference:
  - Work through caregiver
  - Work with caregiver-child dyad (parent may need individual work due to stress/anxiety)
  - Individual work with the child
AACAP Guidelines

- Children who meet criteria for RAD and who display aggressive and oppositional behavior require adjunctive treatments
  - Treatments used for the appropriate co-occurring disorder
  - Cautious approach to pharmacological intervention. No trials with RAD have been conducted
- Interventions designed to enhance attachments that involve non-contingent physical restraint or coercion, reworking trauma or promotion of regression have no empirical support and have been associated with serious harm
Some Recommended Treatments

- Watch, Wait and Wonder (Cohen et al.)
- Manipulation of Sensitive Responsiveness (van den Boom)
- Modified Interaction Guidance (Benoit, et al)
- Preschool Parent Psychotherapy (Toth et al.)
- Parent-Child Psychotherapy (Lieberman et al.)
Differential Diagnosis

- Developmental Disorders/PDD
- Social Phobia
- Schizophrenia
- ADHD
- Behavior Disorders
- William’s Syndrome
- “Affectionless Psychopath” (antisocial & aggressive)
  - No direct link found with RAD
  - RAD may be at risk for aggression, but not a sign of RAD
Post Traumatic Stress Disorder

- Criteria of experiencing life threatening trauma
- What is viewed as inhibited attachment similar to hyperarousal of PTSD
- No studies on the co-morbidity of PTSD and RAD
- Emotional regulation problems and aggression are not core symptoms of RAD
Trauma

- Neglect and abuse are defined as traumas
- Long term impact on mental and physical health
- RAD maladaptive care and problems with attachment to caregiver prior to 5 y/o
Without intervention, adverse childhood events (ACEs) may result in long-term disease, disability, chronic social problems and early death. Importantly, intergenerational transmission that perpetuates ACEs will continue without implementation of interventions to interrupt the cycle.

<table>
<thead>
<tr>
<th>Adverse Childhood Experiences</th>
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<tbody>
<tr>
<td>• Abuse of Child</td>
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<tr>
<td>• Psychological abuse</td>
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<td>• Physical abuse</td>
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<td>• Sexual abuse</td>
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<tr>
<td>• Trauma in Child’s Household Environment</td>
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<tr>
<td>• Substance Abuse</td>
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<tr>
<td>• Parental separation &amp;/or Divorce</td>
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<td>• Mentally ill or suicidal Household member</td>
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<td>• Violence to mother</td>
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<td>• Imprisoned household member</td>
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<tr>
<td>• Neglect of Child</td>
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<tr>
<td>• Abandonment</td>
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<tr>
<td>• Child’s basic physical &amp;/or Emotional needs unmet</td>
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<tr>
<th>Impact of Trauma &amp; Adoption of Health Risk Behaviors</th>
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<tr>
<td>Neurobiologic Effects of Trauma</td>
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<tr>
<td>• Disrupted neuro-development</td>
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<td>• Difficulty controlling anger</td>
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<td>• Hallucinations</td>
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<td>• Depression</td>
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<td>• Panic reactions</td>
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<td>• Anxiety</td>
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<td>• Multiple (6+) somatic problems</td>
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<td>• Impaired memory</td>
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<td>• Flashbacks</td>
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<tr>
<td>Health Risk Behaviors</td>
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<td>• Smoking &amp;/or Drug abuse</td>
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<td>• Severe obesity</td>
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<td>• Physical inactivity</td>
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<tr>
<td>• Self Injury &amp;/or Suicide attempts</td>
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<td>• Alcoholism</td>
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<tr>
<td>• 50+ sex partners</td>
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<tr>
<td>• Sexually transmitted disease</td>
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<tr>
<td>• Repetition of original trauma</td>
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<tr>
<td>• Eating Disorders</td>
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<tr>
<td>• Dissociation</td>
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<tr>
<td>• Perpetrate domestic violence</td>
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| Long-Term Consequences Of Unaddressed Trauma        |
| Disease & Disability                                |
|   • Ischemic heart disease                         |
|   • Cancer                                         |
|   • Chronic lung disease                           |
|   • Chronic emphysema                              |
|   • Asthma                                         |
|   • Liver disease                                 |
|   • Skeletal fractures                             |
|   • Poor self rated health                         |
|   • HIV/AIDS                                       |
| Social Problems                                    |
|   • Homelessness                                   |
|   • Prostitution                                   |
|   • Delinquency, violence & criminal Behavior      |
|   • Inability to sustain employment-               |
|   • Re-victimization: rape; domestic Violence      |
|   • Inability to parent                             |
|   • Inter-generational transmission Of abuse       |
|   • Long-term use of health & social services      |

Impact of Trauma

- Affect Dysregulation – 61.5%
- Attention/Concentration – 59.2%
- Negative Self-Image – 57.9%
- Impulse Control – 53.1%
- Aggression/Risk-taking – 45.8%
- Somatization – 33.2%
- Overdependence/Clinginess – 29.0%
- ODD/Conduct Dx – 28.7%
- Sexual Problems – 28.0%
- Attachment Problems – 27.7%
- Dissociation – 25.3%
- Substance Abuse – 9.5%
Impact of Trauma

Strong and prolonged activation of the body’s stress management systems in the absence of the buffering protection of adult support, disrupts brain architecture and leads to stress management systems that respond at relatively lower thresholds, thereby increasing the risk of stress-related physical and mental illness.
Impact on Parents/Caregivers

- Depression
- Lack of trust, particularly of authority
- Impaired Social/Sexual Relationships
- Hypervigilence
- Inertia
- Substance abuse/self-medicating
- Mental Illness
- Emotional Dysregulation
Assessment Instruments

- **Child**
  - Traumatic Events Screening Inventory (0-6)
  - Trauma Symptom Checklist for Young Children (3-12)
  - Violence Exposure Scale for Children-Preschool (4-10)

- **Parent Stress**
  - Life Stressor Checklist
  - Parenting Stress Index
Evidence Based Practices for Trauma

- Parent-Child Interaction Therapy (2-7)
- Combined Parent- Child CBT (3-17 at-risk for physical abuse)
- Trauma Focused CBT (0-55)
- Alternatives for Families-CBT (physical abuse)
- Child Parent Psychotherapy (0-5)