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# Reactive Attachment Disorder in Children

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## Abstract

Reactive Attachment Disorder as a whole is a disorder that shows itself in young children. It then has the possibility of affecting the rest of the child's life and the people that surround the child. There are two types of Reactive Attachment Disorder. The first type is the emotionally withdrawn/inhibited type. This can manifest itself in a few different ways, but the main way is through the child lashing out in fear or anger. This is due to the lack of healthy attachments in their lives. The second subtype is the disinhibited type. This also can manifest itself in multiple different ways, but the most present symptom is a child seeking attention from strangers and not setting any boundaries. This again is due to the lack of healthy attachments that they have formed, so they look for attachments in unhealthy and sometimes unsafe places. Reactive Attachment Disorder can seem daunting, but there are options to help the children and their families. One treatment option that has significant beneficial results is therapy. This is highly recommended by doctors and physicians.

I chose to write about Reactive Attachment Disorder because it is a large issue in the Orphans and Vulnerable Children population. I started to hear about it over the past couple of years due to some family friends who have adopted children who are suffering from this disorder. I have been really interested in it ever since I heard about it, because I have seen how it negatively affects families and their children. I have only ever heard about it from other people's experiences, so I wanted to research it myself. I wanted to better understand the cause of Reactive Attachment Disorder and see if there is a successful treatment for it. Throughout my research I found the things that I was looking for and so much more.

Reactive Attachment Disorder (RAD) is "a condition in which an infant or young child does not form a secure, healthy emotional bond with his or her primary caretakers" ("Reactive Attachment Disorder," 2018). This disorder is a common occurrence for children who have been raised in institutions or in a neglectful situation. In many cases, it is common for children to be misdiagnosed as having other behavioral issues instead of RAD ("Reactive Attachment Disorder," 2018). The children are misdiagnosed because their symptoms can commonly be attributed to other disorders, some examples include "depression, anxiety, attention deficit-hyperactive disorder, oppositional defiant disorder, conduct disorder, genetic or neurological disorders or autism spectrum disorder" (Ellis & Saadabadi, 2019). For this reason, it is crucial to know what RAD is, and how it manifests itself in the lives of children.

**History**

John Bowlby was one of the first psychologists to really study attachment disorders and how these disorders come to be. Bowlby mainly studied the relationship between the mother and the child, but his theory can apply to a child and their most prevalent caregiver (Team, G. T. E., 2015). Through his studies he found that "children come into the world biologically pre-programmed to form attachments with others, because this will help them to survive" (Mcleod, 2017). Initially as an infant, they will only form one or two attachments, and these figures will act as "a secure base for exploring the world" (Mcleod, 2017). The attachment that the infant makes is an example for them to follow in all of their future social relationships. This means that if the attachment it disrupted "during the critical two-year period," (Mcleod, 2017) there can be immense consequences that the child has to live with, and sometimes these consequences are irreversible (Mcleod, 2017). Bowlby theorized that when a child is in distress, they are able to let their caregiver know. The child can use "crying, smiling, and locomotion" (Mcleod, 2017) to

display distress. However, if the child's distress signaling continually goes unanswered due to the fact that the caregiver is not present or they simply choose to ignore the child, there can be severe issues that arise later on in that child's life.

**Causes of Reactive Attachment Disorder**

Reactive Attachment Disorder can be caused by a number of different things, but as mentioned before, the main cause is the caregiver's actions or lack thereof. RAD most commonly starts between the ages of 9 months and 5 years old ("Reactive Attachment Disorder," 2018). Some situations that commonly lead to this are neglect towards the child's emotional needs for "comfort, stimulation, and affection" (Bhandari, 2018), neglect towards their physical needs, and a change of primary caregivers. If a child is passed from care giver to caregiver, it is extremely hard for them to form "stable attachments" (Bhandari, 2018). Children can also struggle to form stable relationships when there is abuse, neglect or institutionalization involved (Vasquez & Stensland, 2015). This then can lead to "an internal working model that views the world as potentially unsafe, or uncaring, along with the perception of feeling unwanted or unloved" (Vasquez & Stensland, 2015).

Each person has an Internal Working Model (IWM) that "consists of mental representations that form both a sense of self-worth and perception of how safe it is to interact with the external environment" (Vasquez & Miller, 2017). Bowlby found that there are three main features of the IWM. The first feature is "a model of others as being trustworthy" (Mcleod, 2017) or not. This helps the child decide who is a safe person that they want to include in their life and who is not. The second feature is "a model of the self as valuable" (Mcleod, 2017). The third and final feature is "a model of the self as effective when interacting with others" (Mcleod, 2017). This plays a huge role in how children interact with anyone around them, including other

children, as well as, adults. The factors that shape a child's IWM are "rooted in implicit memory systems" (Vasquez & Miller, 2017). This means that when a child is neglected or there is persistent disregard for their needs, the child will begin to realize that they are not cared for and this will shape their development. According to Vasquez and Miller, a very common example of this can be found in how infants are treated when they cry.

> Infants who experienced repeated instances of neglectful caregiving may develop an implicit understanding that basic help-seeking behaviors are ineffectual. Eventually their IWM would form the perspective that they are undervalued and that the external environment cannot provide adequate resources and/or safety. (Vasquez & Miller, 2017)

So, if a baby cries to get the parent's attention, but is ignored over and over again, the baby will learn that no one is going to respond to their cries. The end result: the baby stops crying. Their perception that they are undervalued and will not be taken care of will be stored in their IWM as they grow up. This can then lead to a lifestyle that includes "physical aggression, lying, stealing, and hoarding food, which can occur without conscious thought and seemingly lacking in reason" (Vasquez & Miller, 2017). These behaviors take place because the child is focused on preserving their own life and meeting their own needs. It also "increases the risk of anxiety, depression, hyperactivity, and reduces frustration tolerance" (Ellis & Saadabadi, 2019). Bowlby found that the formable period of a child's IWM is when they are three years old (Mcleod, 2017). This is yet another reason that attaching to a caregiver is such a crucial relationship that children need.

**Emotionally Withdrawn/Inhibited**

Reactive Attachment Disorder can manifest itself in multiple ways, therefore, it is divided into two different subtypes. The first subtype is the emotionally withdrawn/inhibited type. "This can include a lack of attachment-related behaviors in times of stress, irritability that is out of

proportion to the situation, episodes of fear and hypervigilance, and severe emotional dysregulation" (Vasquez & Miller, 2017). In some cases, this can also include the child not responding to others in a healthy manner, whether that is in fear or aggression (Vasquez & Stensland, 2015). Bowlby found that violence typically comes from kids that experience multiple separations, and even more so, children that are "constantly subjected to the threat of being abandoned" (Vasquez & Stensland, 2015). Along with lashing out in aggression, children with this subtype have been known to throw raging tantrums. These tantrums are caused by the situation that the child is in, and the amount of difficulty they are facing when trying to adapt to the environment around them (Vasquez & Miller, 2017). These tantrums can include any of the following: screaming, throwing things, aggression, or running away from the situation that they are faced with (Casa, n.d.). Some other common symptoms that come along with the emotionally withdrawn/inhibited type are the child being detached, unresponsive or resistant to comforting, and excessively inhibited (holding back) emotions (Bhandari, 2018). This type is more easily treated, and, if caught at a younger age and given the proper attention and care, the child's symptoms can vanish (Vasquez & Miller, 2017).

**Disinhibited**

The second subtype is the disinhibited subtype. This type is "categorized by a child displaying a lack of selectivity in choice of attachment figures" (Vasquez & Miller, 2017). This can look like a child lacking any hesitation when meeting a stranger. Children with this kind of subtype commonly seek inappropriate attention from strangers. This can exemplify itself in the child wanting a stranger to pick them up, hold their hand, or hug them ("Attachment Disorders," 2014). The child usually has no regard for their personal safety when it comes to attention from others (Vasquez & Miller, 2017). This can be a very dangerous thing for a child, because they do

not fear strangers, and they desire physical affection from wherever and from whoever they can find it. They have a definite “lack of appropriate physical boundaries” and can find themselves in risky situations (Vasquez & Stensland, 2015).

**Commonalities**

Overall, Reactive Attachment Disorder is separated into these two categories, but there are some common symptoms that fall into both categories. One example can be found in the child’s eye contact. Children suffering from RAD usually avoid eye contact as much as possible. To the child, it is “emotionally arousing”, and they risk seeing anger on their caregiver’s face (Casa, n.d.). Another symptom that can be found is in the way that the children victimize themselves. This looks like them not taking responsibility for anything, but “inwardly [they] believe they are responsible for everything that has happened” (Casa, n.d.). This usually leads to an immense and overwhelming sense of guilt. This heavy guilt can then lead to the child rejecting any love from their primary caregiver (Casa, n.d.). Another big symptom is that the child is focused only on the present. This can be a struggle for them because they do not learn from events in their past. Also, with their focus on the present, they can become overwhelmed when they attempt to plan for the future.

Even though there is a long list of symptoms that these children display, the unique thing is that most outsiders do not see these symptoms. The people who see the symptoms the most are the caregivers of the children, or those that the children live with. The caregivers will see the raging, destructive, and aggressive behavior that comes along with the disorder. They will also experience the stealing and lying as well as the constant attention seeking from the child (Casa, n.d.). All of these things are symptoms that have been researched. However, the fascinating thing is that children with RAD act much differently around others. To outsiders, the children seem to

be “charming and engaging” (Casa, n.d.). Also, the child will usually appear as a victim because they play this role so well (Casa, n.d.). Since it can be difficult for others to truly see how the child is acting, it can be hard to diagnose reactive attachment disorder. A pediatric psychiatrist or psychologist needs to be consulted in order to truly diagnose this disorder (“Reactive Attachment Disorder,” 2017). Unfortunately, there are no set tests to diagnose the child. Instead, the doctors will perform an evaluation on the child (Shaw & Paez, 2007). This can include observing their “interaction with [the] parents or caregivers,” collecting a history of the child’s actions, observing them in various settings, “evaluat[ing] the parenting and caregiving styles and abilities,” and observing the home life and care of the child (“Reactive Attachment Disorder,” 2017).

**Treatment**

Though the symptoms of Reactive Attachment Disorder seem very bleak, there are some possibilities for treatment. Doctors have found that if this disorder is caught and acted upon early, then the child has a greater possibility of improvement (“Reactive Attachment Disorder,” 2017). This means that caregivers, teachers, and any adults that are prevalent in a child’s life need to be vigilant and actively looking for signs. When doctors are treating children with this disorder, there is no set technique that they follow. However, since RAD “is associated with problems concerning attention as well as aggressive and defiant behaviors,” (Buckner, Lopez, Dunkel, & Joiner, 2008) treatments are usually directed towards managing these symptoms. There are typically four different approaches that doctors take when treating a child with Reactive Attachment Disorder. The first one is to “encourage the child’s development by being nurturing, responsive, and caring” (“Reactive Attachment Disorder,” 2017). This helps negate the original acts that caused the child to develop RAD. The second approach is to “provide

consistent caregivers to encourage a stable attachment for the child" ("Reactive Attachment Disorder," 2017). This, again, allows the child to have someone present that they trust and that they know will take care of them. The third option is to "provide a positive, stimulating, and interactive environment for the child" ("Reactive Attachment Disorder," 2017). This will help the child's brain to develop in a healthy manner, and it allows them to interact with their caregivers in a positive way. The fourth approach is to address the child's medical safety and housing needs, as appropriate ("Reactive Attachment Disorder," 2017). This is a crucial option as sometimes the child needs to be removed from the home. Although though this is not the ideal outcome, it needs to be kept in mind if it does come down to the child being removed. Some doctors also suggest "psychotherapy for the child, family therapy, and parenting training" ("Quick Facts on Reactive Attachment Disorder," n.d.). Studies have found that therapy for the child and the family has shown immense results (Wimmer, Vonk, & Bordnick, 2009). All of these methods take time, and some of them are not guaranteed to work, but overtime the hope is that they will benefit the child's life. No matter which approach the family and doctor decide to take, the purpose of the treatment is to provide for the child a "safe haven and secure base" and to "rebuild human connections" (Shi, 2013).

**Conclusion**

In conclusion Reactive Attachment Disorder is a very serious disorder that can affect children, their families, and everyone around them. It is a disorder that influences the actions of the child and the relationships that they either choose to have or refrain from having with others. It is very important for individuals to be informed on RAD so that they have the ability to recognize the symptoms in a child and better know what course of action is needed to help that child. As stated before, this disorder can seem extremely daunting. However, there are doctors

and physicians who have found successful ways to help children and their families who are living a life affected by this disorder.

# References

Attachment Disorders. (2014, January). Retrieved November 13, 2019, from https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF Guide/Attachment-Disorders-085.aspx.

Bhandari, S. (2018, May 20). Mental Health: Reactive Attachment Disorder. Retrieved November 9, 2019, from https://www.webmd.com/mental-health/mental-health-reactive attachment-disorder#1.

Buckner, J. D., Lopez, C., Dunkel, S., & Joiner, T. E. (2008, August 13). Behavior management training for the treatment of reactive attachment disorder. Retrieved November 12, 2019, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2566997/.

Casa. (n.d.). Reactive Attachment Disorder: How to Help the Parents Heal the Child. Retrieved November 19, 2019, from https://www.ohiocasa.org/wp-content/uploads/2017/03/T08 Hustead-Reactive-Attachment-Disorder.pdf.

Ellis, E. E., & Saadabadi, A. (2019, January 13). Reactive Attachment Disorder. Retrieved November 9, 2019, from https://www.ncbi.nlm.nih.gov/books/NBK537155/.

Mcleod, S. (2017). Bowlby's Attachment Theory. Retrieved November 9, 2019, from https://www.simplypsychology.org/bowlby.html.

Quick Facts on Reactive Attachment Disorder. (n.d.). Retrieved November 13, 2019, from https://childmind.org/article/quick-facts-on-reactive-attachment-disorder/.

Reactive Attachment Disorder. (2018, August 21). Retrieved November 11, 2019, from https://my.clevelandclinic.org/health/diseases/17904-reactive-attachment-disorder.

Reactive attachment disorder. (2017, July 13). Retrieved November 12, 2019, from https://www.mayoclinic.org/diseases-conditions/reactive-attachment-disorder/symptoms

causes/syc-20352939.

Shaw, S. R., & Paez, D. (2007). Reactive Attachment Disorder: Recognition, Action, and Considerations for School Social Workers. Children & Schools, 29(2), 69–74. doi: 10.1093/cs/29.2.69

Shi, L. (2013). Treatment of Reactive Attachment Disorder in Young Children: Importance of Understanding Emotional Dynamics. The American Journal of Family Therapy, 42(1), 1 13. doi: 10.1080/01926187.2013.763513

Team, G. T. E. (2015, July 23). John Bowlby (1907-1990). Retrieved November 10, 2019, from https://www.goodtherapy.org/famous-psychologists/john-bowlby.html.

Vasquez, M., & Miller, N. (2017). Aggression in Children With Reactive Attachment Disorder: A Sign of Deficits in Emotional Regulatory Processes? Journal of Aggression, Maltreatment & Trauma, 27(4), 347–366. doi: 10.1080/10926771.2017.1322655

Vasquez, M., & Stensland, M. (2015). Adopted Children with Reactive Attachment Disorder: A Qualitative Study on Family Processes. Clinical Social Work Journal, 44(3), 319–332. doi: 10.1007/s10615-015-0560-3

Wimmer, J. S., Vonk, M. E., & Bordnick, P. (2009). A Preliminary Investigation of the Effectiveness of Attachment Therapy for Adopted Children with Reactive Attachment Disorder. Child and Adolescent Social Work Journal, 26(4), 351–360. doi: 10.1007/s10560-009-0179-8