Reactive Attachment Disorder: What Do We Really Know About This Diagnosis?

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Over the past several years, increased attention has been paid to children who are alleged to have difficulties bonding and attaching to others. More specifically, there has been a surge in the use of reactive attachment disorder (RAD) as a diagnosis to describe a wide range of problem behaviors and disturbed interactions between infants or children and their caregivers.

Despite this proliferation in the use of the RAD diagnosis and an increased focus on attachment problems in general, there is considerable disagreement about what RAD actually is and, perhaps more importantly, how to treat the problems purportedly displayed by children with this diagnosis. The focus of this article is to (1) provide an overview of the RAD diagnosis and problems associated with its use, (2) discuss concerns related to current treatment approaches, and (3) present some guidelines for possible interventions for children displaying attachment-related difficulties. (For a more thorough discussion of these topics, please refer to Hanson and Spratt, 2000.)

DSM-IV Diagnostic Criteria

To begin, it is important to highlight the criteria specified in the *American Psychiatric Association, Diagnostic and Statistical Manual*, fourth edition (DSM-IV) (1994), for a diagnosis of RAD. According to the DSM-IV, reactive attachment disorder (RAD) refers to "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years" (p. 116). Children may be classified as having the Inhibited Type, which is described as a "persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions," or a Disinhibited Type, characterized by "the failure/inability to discriminate in their social interactions (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures)" (p. 116).

In addition to demonstrating the inhibited or disinhibited type of behaviors, the DSM-IV specifies that there must be evidence of pathogenic care, which refers to "persistent disregard" of the child's basic physical or emotional needs, or frequent disruptions in caregiving "that prevent formation of stable attachments (e.g., frequent changes in foster care)" (p. 118). By definition, children who have experienced abuse or neglect meet the pathogenic care requirement, which may explain the high rates of the RAD diagnosis among maltreated children. Another important issue regarding the DSM-IV RAD diagnosis is that the foregoing description is all that is specified. No additional information is provided, yet children with a host of severe behavioral and emotional problems are being diagnosed with RAD.

Another definitional issue with the RAD diagnosis is that attachment-related problems are not confined to the child's primary caregiver. As stated by the DSM-IV, the child's attachment difficulties are evidenced across multiple settings and with multiple caregivers (Richters & Volkmar, 1996). Despite this specific criteria, children whose relationship difficulties are solely confined to interactions with their primary caregiver, but not evidenced with others (e.g., teachers, therapists), are still receiving the RAD diagnosis (Zeanah, 2000).

Problems With the RAD Diagnosis

A significant problem with the RAD diagnosis is its apparent misuse and overuse. Children exhibiting behaviors that extend beyond DSM-IV criteria are being given the RAD diagnosis. For example, Reber (1996) provides a table that lists common symptoms of RAD obtained from the files of the Family Attachment Center in Salt Lake City, Utah. The list includes problems or symptoms across multiple domains (social, emotional, behavioral, and developmental) and ranges from DSM-IV criteria for RAD (e.g., superficial interactions with others, indiscriminate affection towards strangers, and lack of affection towards parents) to nonspecific behavior problems including destructive behaviors; developmental lags; refusal to make eye contact; cruelty to animals and siblings; lack of cause and effect thinking; preoccupation with fire, blood, and gore; poor peer relationships; stealing; lying; lack of a conscience; persistent nonsense questions or incessant chatter; poor impulse control; abnormal speech patterns; fighting for control over everything; and hoarding of or gorging on food.

Clearly, this laundry list of symptoms and problem behaviors extends far beyond the criteria provided by the DSM-IV and might more appropriately indicate other types of disorders, such as conduct disorder, attention deficit-hyperactivity disorder, or other disruptive behavior problems that may not specifically stem from dysfunctional attachment. Thus, careful adherence to diagnostic criteria is important before labeling a child with a highly controversial and potentially stigmatizing diagnosis.

A second problem with the RAD diagnosis is that it falls under the umbrella of a much broader array of attachment-related problems. Difficulties in attachment may or may not meet DSM-IV criteria for RAD, and this important distinction is not typically made by the diagnosing clinician. A related problem with the use of both the RAD diagnosis and attachment problems in general centers on issues related to co-morbidity. Simply stated, children with attachment problems typically display other behavioral and emotional problems that may not be diagnosed. Examples include posttraumatic stress disorder (PTSD), attention deficit-hyperactivity disorder (ADHD), conduct disorder, anxiety disorders, or impulsive disorder. The reason why this issue becomes particularly important is that these other diagnoses, which may more accurately reflect the problems of the child, have evidence-based treatment interventions available for use. In contrast, there are *no* empirically validated treatments for RAD. The unfortunate outcome is that when practitioners focus on the RAD diagnosis, rather than on potentially more applicable diagnoses, they may ignore empirically validated interventions that could have a significant impact on the child's behavior.

A third problem is that the DSM-IV specifies that evidence of attachment-related problems and pathogenic care must be evident prior to age 5. However, for many children, historical information on their infancy and early childhood is not available. Thus, in theory, the RAD diagnosis should *not* be applied to any child for whom this early historical information is unknown. In practice, however, children are diagnosed with RAD, despite the absence of this critical information. An assumption is made about their early years, without available data.

A fourth concern with the RAD diagnosis is that there are no standerized measures, apart from the strange situation measure used only with infants and toddlers. In addition, subsequent studies indicated that attachment style was related to a host of other factors including confusion, fear, ambivalence, aggression, and hypervigilance in interactions with others. However, strange situation procedures are time-intensive, require extensive training, and are unlikely to be utilized by the average practitioner. The outcome of this is that practitioners may rely on unvalidated, poorly developed measures to assess for attachment problems or use no type of objective measurement at all.

Perhaps the biggest concern related to RAD and attachment problems, overall, is the complete absence of any evidence-based treatment interventions. Despite this (or perhaps as a consequence of this), many practitioners are relying on highly controversial and potentially harmful treatment interventions for children identified as suffering from attachment problems.

Coercive Treatment Techniques

Beverly James (1994) provided an excellent overview of some of the coercive treatment techniques being utilized with attachment-disordered children. These treatment interventions have variously been referred to as holding therapy, attachment therapy, and rage reduction therapy. The basic components of the treatment procedures include the following: (1) prolonged restraint (other than for protection); (2) prolonged noxious stimulation; and (3) interference with body functions. During these procedures, a child is held immobile by one and up to several adults. While the child is restrained, a clinician makes deliberate attempts to provoke the child by yelling repeatedly and applying other noxious stimuli (i.e., poking ribs, continuously tapping chest or feet, tickling, pulling toes, moving child's head from side to side, covering child's eyes, pinching child's nose). Eventually, the child becomes physically and emotionally aroused and may scream or cry. At this point, the child is typically soothed, rocked, and told that he or she has done a "good job." These procedures may be conducted over several hours and may be repeated daily.

The alleged premise of such techniques is that the child's repressed rage interferes with the ability to form attachment. Prolonged restraint, noxious stimulation, and interference with bodily functions release the rage and convey to the child that adults can and will control him. When a child "surrenders," he or she is given to the caregiver(s) and the child will now "attach."

Critique of Coercive Techniques

In addition to the potential for physical harm and even death, as in several known cases in this country, parents may be told that this type of intervention is the only way to keep their child from institutionalization or a career as a serial killer and that alternative conventional treatments will not work for their child. Professionals who express concerns about attachment therapy may be dismissed as misinformed or as having "unresolved issues of their own." It is critical to keep in mind that many children who get these treatments are extremely vulnerable. Because of the criteria regarding evidence of pathogenic care, many children given the RAD or attachment disorder diagnoses and thus subjected to these treatments have severe abuse/neglect histories and multiple out-of-home placements. This vulnerable population is at high risk of long-term difficulties even before being subjected to highly controversial and potentially traumatizing interventions (James, 1994).

Proponents of attachment therapy argue that it has been mischaracterized. They prefer to describe attachment therapy as confrontational and intense but also nurturing and sensitive. Proponents have presented anecdotal statements from parents who attest that attachment therapy worked where all else failed. However, anecdotes aside, the fact remains that there is simply no empirical evidence at present to support the assertion that attachment therapy is more effective, or even as effective, when compared with accepted and conventional approaches.

Indeed, the entire underlying rationale for the intervention is faulty. There are simply no data to postulate that children with attachment problems exhibit signs of repressed rage or that intentionally provoking a child's anger will result in ready attachment with a caregiver. As stated above, one of the most difficult aspects of attachment problems in general, and the RAD diagnosis in particular, is the absence of evidence-based interventions to address these difficulties. This makes it particularly difficult to make specific recommendations regarding appropriate, effective interventions. The important take-home point is that *any* intervention having even the potential to cause harm should not, under any circumstances, be utilized. In addition, it is incredibly rare that a child displaying attachment difficulties is not also displaying other behavioral or emotional problems.

A more careful focus on these behavioral and emotional problems appears to be the better way to address these children's difficulties, particularly because evidence-based interventions are available for other related behavior and emotional problems (e.g., treatments for ADHD, CD, PTSD) and a reliance on such interventions, whose goal is to reduce behavior and emotional problems, should have the added effect of improving caregiver-child relationships.

Guidelines for Working With Children With RAD

Thus, despite the absence of RAD-specific evidence-based interventions, there are guidelines to follow when working with children who appear to have difficulties with attachment. Three important components comprise this discussion: First, careful assessment is critical. Second, specific preconditions should be in place before attempting any specific intervention. Third, when possible, evidence-based interventions that target observed behavioral and emotional difficulties should be utilized. In the absence of strong, empirical data, treatment interventions should be selected that have no potential for harm, that have a clear, cogent rationale, and that would be generally accepted among most clinicians working with children. Each of these points is discussed below:

Careful Assessment Is Critical

It is important for assessment to determine whether the child meets criteria for other DSM-IV diagnoses that may lend themselves to the use of evidence-based interventions. Assessment should be multimodal and multirespondent. In other words, whenever possible, it is important to collect information from multiple sources, such as the child's caregiver(s), teachers, previous therapists, physicians, and the child directly. Assessment should also include standardized self-report measures (depending on the age of the child) as well as direct observation of child-caregiver interactions. It cannot be emphasized enough that if attachment problems are being reported, it is critical that assessment includes observations of the child, the child's caregivers, and other adults in the home, school, and clinic settings. There is also no substitute for a thorough clini-

cal interview. This can include both structured as well as unstructured components but should assess developmental history, medical history, family medical and psychiatric history, school functioning, and treatment history.

Preconditions to Treatment

Before any intervention can begin, certain preconditions need to be in place (Swenson & Hanson, 1998). Although many of these are intuitive, they can often be overlooked or assumed as already present. First, it is crucial that the child be in a safe environment. If a child has been abused and still has contact with the perpetrator, treatment will be completely ineffective. The child has to feel that he or she is safe from harm, and this includes the potential for future harm.

The second component includes the importance of providing a consistent, predictable environment in which the child feels some sense of control both within the home and in the therapeutic environment. As much as possible, stability and predictability can be enhanced by arranging set appointment days, times, and settings and by establishing a routine for the course of the therapy session. To further enhance a feeling of control, the therapist can offer the child some reasonable choices, for example, selection of a specific medium to work with (e.g., use of crayons versus markers) or some variation during the therapy session (e.g., meeting caregiver first, then child, or visa versa). It will also be up to the practitioner to set clear rules, consequences, and appropriate boundaries. Again, all of these components will increase feelings of safety, trust, and control, which will ultimately facilitate the therapeutic process.

The third, perhaps obvious, component is crisis stabilization. If a child is suicidal or homicidal, for example, any attempts to focus on trauma or family issues will be pointless until the crisis is resolved. However, it is important to avoid the trap of focusing exclusively on the weekly "crisis" at the expense of the specific goals of treatment. Finally, and perhaps most importantly, when addressing attachment-related issues, the inclusion of a supportive caregiver cannot be overstated. Caregivers can benefit from instruction in behavior management and positive parenting practices as well as from education regarding their child's trauma history, symptoms, and risk reduction strategies.

Interventions

Interventions should include individual therapy with the child; individual therapy with caregivers; dyadic therapy with child and caregivers; family therapy; and home-based services. Because the majority of children referred for attachment issues also display significant behavior problems, several evidence-based interventions can be utilized, such as parent-child interaction therapy (Hembree-Kigin & McNeil, 1995). Involvement of the caregiver is critical because if the child is experiencing problems in attachment, it makes intuitive sense to include the caregiver in all phases of treatment. The caregiver can benefit from a focus on behavior management skills training, and when behavior problems improve, a more positive child-caregiver relationship can develop.

Traumatic events possibly experienced by the child should also be addressed. That is, the RAD diagnosis requires evidence of pathogenic care. Many children who have histories of physical abuse, sexual abuse, and/or domestic violence may receive a RAD diagnosis, but trauma-related symptoms are often left untreated. Thus, clinicians need to note any symptoms of fear, anxiety, and other trauma-related problems. Further, interventions in the area of child maltreatment have empirical support and should be utilized. These include psychoeducation, affective processing, instruction on the use of adaptive coping and anxiety management skills, and gradual exposure (e.g., Cohen & Mannarino, 1996; Deblinger & Heflin, 1996; Deblinger, Steer, & Lippman, 1999; Deblinger, McLeer, & Henry, 1990; Stauffer & Deblinger, 1996). Deblinger and colleagues have demonstrated that outcome is improved when a supportive caregiver is included in the treatment process (e.g., Deblinger & Heflin, 1996; Deblinger, et al., 1999; Deblinger, et al., 1990; Stauffer & Deblinger, 1996).

In sum, this article has addressed a number of specific concerns regarding the diagnosis of RAD and the use of controversial treatments. With respect to diagnosis, it appears that the RAD diagnosis may be overused, particularly among children with a trauma history. A thorough assessment by a professional can examine potential attachment difficulties as well as recognize more prevalent diagnoses, such as anxiety. Second, there is no empirical evidence for any treatment intervention for attachment disorders at the present time. A reliance on controversial, unproven treatments can have a severely detrimental, even fatal, effect on children. However, if practitioners assess and target specific behavior and emotional problems, it may be possible to rely on proven, well-established treatment interventions. If, as the DSM-IV diagnosis specifies, these problems begin at a very early age, it is important to recognize that progress will be slow, especially in older children. There simply is no overnight "fix." To the extent that practitioners and caregivers recognize this fact, they will avoid novel treatments promising a quick cure.

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Note: References inadvertently omitted from this article will be included in the forthcoming Special Issue, Part 2.