Reactive Attachment Disorder

Carolyn R. Fallahi, Ph. D., Associate Professor of Psychology, CCSU

Attachment: The bond between parent and baby – A model for future relationships.
Sigmund Freud (1856-1939) & Oral needs
John Bowlby (1907-1990)

- Separated children in orphanages
What do children look like who have Secure Attachment?

- Positive self-esteem
- Loving relationships
- The ability to trust
- Effective coping skills,
- The ability to develop independence.
- Success in school
- Maturity, loyalty, and the ability to be caring partners & parents
- Prosocial behavior
- Psychic Resilience
Functions of Secure Attachment

- Basic human need to stay close to one another for safety, protection, and survival
- Secure base
- Trust and reciprocity
- Attachment affects brain development
- Self-regulation
- Beliefs about the world
- Morality
Attachment is a basic human need

- Rene Spitz – orphanages
- Failure to thrive syndrome
Attachment

Universality of stages when separated from mother.

Stage 1: Protest

Stage 2: Despair

Stage 3: Detachment
There is a biologically based system of attachment that is responsible for the powerful emotional relationship between mother and child.

How does attachment happen? Bowlby (and Freud): feeding???????
The role of IMPRINTING! Lorenz (1943) felt that attachment was similar to imprinting in geese.

Attachment is innate and adaptive for both the mother and child.

Important for survival.
Harry Harlow

Harry Harlow disputed the role of oral satisfaction.
Mary Ainsworth (1913-1999)

Observed small children and their mothers during 2-hour visits in their homes every week making very detailed records both of the mother’s care-giving behavior and the child’s attachment and separation behavior.
Ainsworth’s Strange Situation

Ainsworth developed a test-like standard procedure, called the “Strange Situation,” to study children’s attachment in the laboratory setting.

Measure 4 behaviors:
1. Willingness to explore
2. Separation anxiety
3. Stranger anxiety
4. Reunion Behavior
The Strange Situation
Infant characteristics that promote attachment

“Kewpie doll” appearance
Rooting, sucking, grasping
Reflexes
Cooing, babbling
Smiling
crying
Responsiveness to social overtures
Physically unattractive, e.g. premature
Weak reflexes
Irritable
Few smiles
Unpleasant vocalization, e.g. irritating shrill
Easily over-stimulated
Resists or ignores social overtures
Maternal depression
Abused mother
Mother does not want baby
Mother unable to take lead in establishing interactions
Mother insensitive to infant cues and may under- or over-stimulate child
Several children in family
Poor marital relationship
- Severe emotional trauma experienced by mom during pregnancy.
- Mom is too young to nurture.
- Mom is impoverished.
- Mom is drug addicted.
- Mom has a serious psychiatric disorder.
What about baby factors?

- Serious colic
- Serious ear infections
- Separation from the caregiver
- Abuse and neglect
- Genetic predisposition
- Frequent moves and placements
- Birth trauma
- Undiagnosed or painful illness
• High stress
• Out-of-home placements.
• Lack of support
• Poverty
- **Stages in Social Attachment**
  - Asocial stage – 0-6 weeks
  - Indiscriminate attachment stage – 6 wks to 6-7 months
  - Specific attachment stage – 7-9 months
  - Multiple attachment stage – shortly after stage 3.
Kagan’s Temperament Hypothesis
- Quality of infant’s attachment dependent upon:
  - Easy temperament = secure attachment
  - Difficult temperament = insecure (anx/res)
  - Slow to warm up temperament = insecure (anx / avoidant)
How does attachment help baby?

- Baby is anxious
- Baby seeks closeness from mother
- Mom provides safety & comfort.

What makes baby anxious?
- separated from mother
- encountered threatening unfamiliar situations or strange persons
- Experiences physical pain
- Feels overwhelmed by fantasies/nightmares
Parents need to be sensitive

- Read the child’s signals (e.g. crying)
- Interpret signals correctly.
- Satisfy the child appropriately.
How might parents not respond with sensitivity?

- The parents might not meet the needs of the child.
- The parents may respond in an unpredictable manner.
- The parents may interfere with overreaction, over-alertness, overstimulation, rejection, and neglect.
- The parents may abuse.
The Hierarchy of Attachment Figures

- If the infant is in a threatening situation and the main attachment figure is absent, the child will react with sadness, crying and anger.

- If the primary attachment figure is not available, the child will seek out a secondary attachment figure for emotional security.
Bowlby’s Internal Working Model

- What is an internal working model?
- How does it form?
- We need internal working models in order to have an understanding of our life.
- We are not conscious of our internal working models.
Ainsworth’s (1974) Caregiving Hypothesis

- Attune
- Interpret
- Respond
- Reaction is prompt
Classification of Infant Attachment

Ainsworth

- Secure attachment
- Avoidant attachment
- Ambivalent attachment
- Disorganized attachment
Does an insecure attachment lead to particular psychopathologies?

THE ANSWER IS YES.

Insecure attachment patterns have been found in various childhood phobias, school phobia, and parent’s separation anxiety.
The role of attachment in sociopathy

Antisocial behavior
Medical Disorders
• Chronic diseases
• Heart defects

Premature delivery
• Extremely small infants
• Mixed results for premature children, in general

Parent’s disorders
• Depression
• Psychosomatic illness
• The role of cortisol levels higher

Insecure Attachment
In the extreme, symptoms include:

- Eating Disorders
- Sleep Disorders
- Pottying Problems
What is happening in the brain?

- Excess levels of cortisol = damage in the brain’s hippocampus = memory function = lack of control over emotions.
- Early childhood trauma? Hyperarousal.
1989 = the United States goes into Romania Orphanages

Attachment Disorders become known to the world.

Romanian Orphanages
The relationship of attachment patterns & attachment classifications

Insecure attachment does not equal attachment disorders.
Diagnostic criteria for 313.89 Reactive Attachment Disorder of Infancy or Early Childhood

A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2): (1) persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness) (2) diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures)

B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in Mental Retardation) and does not meet criteria for a Pervasive Developmental Disorder.

C. 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 (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)

D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

Specify type: Inhibited Type: if Criterion A1 predominates in the clinical presentation  Disinhibited Type: if Criterion A2 predominates in the clinical presentation
A Red flag for attachment

- Even in obviously dangerous situations that normally trigger attachment behavior, these children do not turn toward a preferred figure.

- In situations of separation, they do not react with protest. Or…they protest during separation from anyone, without differentiation.

- We do not make this diagnosis until the age of 8 months when stranger anxiety develops.

- Who is at risk? Those who have experienced numerous relational breaks and shifts during infancy or brought up in institutions/multiple foster homes.

- What does ‘no attachment’ look like clinically?

- Undifferentiated attachment behavior.
◆ These children demonstrate excessive clinging
◆ In unfamiliar surroundings or faced with a stranger, they react far more anxiously than one would expect
◆ They seek physical closeness to the attachment figure
◆ They want to be picked up and held at an age that would not be expected, e.g. school age
◆ Even when an attachment figure is holding them, they appear anxious, tense, and suspicious
◆ They react to separation with excessive emotional distress – they cry, rage, and panic, and are inconsolable
◆ The attachment figure herself may avoid separation because she knows how the child’s violent reaction will be
◆ Risk factors????
Aggressive Attachment Behavior

- Children often show aggressive behavior.
  - Physical aggression
  - Verbal aggression
  - Nonverbal aggression
- Oppositional behaviors
- Rejection by peers
- Failure to thrive symptoms
  - Eating
  - Crying
  - Sleep disorders
Attachment Behavior with Role Reversal

- Role reversal between the attachment figure & the child.
- Superficially attached.
Psychosomatic Symptoms
Attachment Disorders

• Psychosomatic symptoms
  • Failure to thrive
  • Physical growth may slow down / halt
• What are the risk factors?
  • Anxiety
  • Paranoia
  • Psychiatric illness
  • Postpartum
• The child’s anger is great because the mother’s behavior cannot be predicted. Mom is ambivalent.
Symptoms of Attachment Disorder

- Behavioral symptoms
- Cognitive symptoms
- Emotional symptoms
- Social symptoms
- Physical symptoms
- Moral symptoms
Common Co-occurring disorders

- ADHD
- Major Depressive disorder or Dysthymia
- PTSD
- Oppositional Defiant Disorder
- Conduct Disorder
- Enuresis/Encopresis
- Bipolar Disorder
The relationship between bonding breaks and attachment.

Examples of bonding breaks.
- Prenatal influences
- Inattentive caregiver
- Situational traumas
- Faulty Parenting
Attachment Disorder
Transmitted intergenerationally

- Children with disordered attachment grow into parents who are not able to provide a secure attachment for their children.
- Instead of providing comfort and support, they are more likely to abuse, neglect, and abandon.
- Pyramid effect = each generation there is a multifold increase in the number of children with attachment disorder.
Research on Insecure attachment

- Levy & Orleans
- Lyons-Ruth
- Levy & Orleans
- Hare
Research on Insecure attachment

- Davis: Serial killers have some of the same symptoms
  - Jeffrey Dahmer
  - Ted Bundy
  - David Berkowitz (son of Sam)
  - Charles Manson
  - Albert DeSalvo (Boston Strangler)
Other Deficits seen

- Deficits in self-regulation
- Impulse control
- Self-soothing
- Initiative
- Perseverance
- Patience
- Inhibition
- Relating skills
- Empathy
- Trust
- Affection
- Reciprocity
- Expression
- Respect
- Attachment deficits
Why has RAD increased?

- Parental substance abuse.
- Childhood poverty and single parenthood = virtually unsupervised children.
- Divorce rates of children have tripled.
- Damaged biological parents, e.g. survivor of childhood sexual abuse, physical abuse, loss of parent, poverty, domestic violence, chronic physical/mental illness.
Why has RAD increased?

- Adolescent parent
- HIV infection
- Combination of all of these factors.
Attachment Therapy – Rebirthing Therapy

- A highly publicized case – 10-year-old Candace Newmaker.
Corrective Attachment Parenting (CAP)

- CAP was developed to meet the needs of children who are showing RAD, experienced maltreatment, significant losses, and disrupted attachment.
- Create a healing environment.
- The parental assessment.
Psychotherapy

- The goal of psychotherapy
- The therapist is an attachment figure
Corrective Attachment Therapy

- Treatment should focus on 5 major areas within the family unit:
  1) Child: address prior psychosocial trauma and disrupted attachment and improve internal working model (belief system) & prosocial coping skills
  2) Parent-child relationships: facilitate secure attachment patterns, including trust, emotional closeness, and positive reciprocity
Corrective Attachment Therapy

3) Family dynamics: modify negative patterns of relating, enhance stability, support, and emotional climate.

4) parents; address family-of-origin issues that inhibit effective personal and interpersonal functioning

5) parenting skills: learn the concepts, attitudes, and skills of Corrective Attachment parenting.
The Mom

- The mom is blamed and targeted.
- The therapist uses mom as the “change agent.”