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Priscilla K. Coleman
Bowling Green State University, Ohio, USA

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Reactive attachment disorder in the context of the family
A review and call for further research

PRISCILLA K. COLEMAN
Bowling Green State University, Ohio, USA

ABSTRACT
Research pertaining to reactive attachment disorder (RAD) is reviewed to clarify existing knowledge about the diagnosis and to identify avenues for enhancing the lives of afflicted individuals and their immediate family members. An overview of literature pertaining to the diagnosis is provided initially. Family experiences associated with the presence of children with significant attachment problems are subsequently examined. The focus is on interrelationships among RAD behavioral characteristics and associated challenges to parents and siblings. Finally, relevant literature derived from different subareas within psychology and from related fields outside the discipline is organized and integrated with the goal of providing direction for future research and attempts to support families.

As I worked in the yard on a bright morning in early June, I glanced up to check on our children, Jill age 5 and Joey nearly 2, who were playing on a porch nearby. From a distance of 15 feet, I could see Joey smiling and waving to me, and then seconds later, without a word, Jill leaned toward her brother and pushed him on the back, sending him reeling down the four steps, where he landed on a slab of concrete. Dashing over to the scene, I found myself trying to comfort my son and tend to his cut knees while simultaneously feeling the urgent anger-laden need to ask my daughter why she did such a thing. Her response to my inquiry was an affectless 'He was in my way'. Of course, my first question was followed by others such as 'Didn’t you realize he would get hurt?' and ‘Did he do something else that bothered you?’ Jill’s reaction was all too familiar. She stood motionless looking back at me with an eerie blank stare, uttering ‘I don’t know’ if anything at all to each successive probe for information. I placed her in a time-out, where she sang and busied herself with imaginary people. As I watched her in time-out, I remember experiencing strong guilt-ridden,
self-recriminating thoughts, worries that my tone was too harsh and that my expectations for her were out of line with her abilities.

We adopted Jill at age 3 and her brother, our biological son, was born 10 months later. Although not an everyday occurrence, incidents like the one described above were frequent and seemed to be outside the realm of normal sibling rivalry or conflict. My struggles to identify and meet Jill’s complex needs and provide a safe nurturing environment for Joey and now Sam, combined with motivation to understand my own emotional reactions to Jill’s behavior, provided a strong impetus for exploration of the available literature on late adoptions. Ultimately this personal journey resulted in a doctorate in developmental psychology, with an emphasis on early socio-emotional development and parenting. My examination of the professional literature eventually led me to the conclusion that Jill suffered from reactive attachment disorder (RAD), a condition which has received considerably less scholarly attention than most other recognized childhood pathologies. The primary aims of this report are to examine current knowledge pertaining to children with attachment problems in the context of the family and to identify avenues for optimizing outcomes for children with RAD and other individuals involved in their lives.

**Current knowledge pertaining to RAD**

Child-caregiver attachment is most frequently defined as an active, affectional, reciprocal, and relatively stable bond that emerges out of repeated interactions over time (Ainsworth et al., 1978). From a secure relationship, a child develops confidence in the caregiver’s physical and psychological availability, and this awareness facilitates environmental exploration (Bretherton, 1985). Secure attachment is likewise associated with the development of positive feelings of worth or an adaptive concept of self (Cummings and Cicchetti, 1990). Conversely, insecure attachment occurs when a child emerges from the infancy period without assurance that his or her primary caregiver is willing and able to respond appropriately to his or her needs. Further, insecure attachment is likely to be correlated with beliefs that one is undeserving of love and affection.

With RAD, socio-emotional supports are either very inconsistent (e.g. frequent caregiver changes) or altogether absent from the child’s immediate environment over an extended period of infancy (e.g. as in institutional rearing). O’Connor et al. (1999) have suggested that with RAD the attachment system is essentially dismantled by children’s experiences, resulting in an interactive behavioral style that is qualitatively distinct from insecure attachment styles (resistant, avoidant, or disorganized). When RAD is present, there is no discriminating attachment behavior and these children
engage in very shallow, emotionally deficient social behavior that is rarely reciprocal.

The few available studies related to RAD tend to focus exclusively on the troubled child despite expanding awareness of the need to utilize a context-sensitive or systems approach to the study of both normative development and pathology (Minuchin, 1985; Sameroff, 1994). This individual orientation seems particularly inappropriate because attachment difficulties are inherently relational and represent an aberration that is a direct result of insufficiencies in the caregiving context. Only minimal or superficial attention has been devoted to the meaning of adopting children with attachment problems from the perspective of the parents and siblings living in the home. However, there is growing awareness that many adoptive parents are unprepared for the unusual demands of rehabilitating institution-reared children (Ames and Carter, 1992). Common among parents adopting an older child who has had insufficient opportunities to form positive attachments is a certain level of naiveté. In particular, there is often a tendency to assume that with sufficient child health and appropriate development in concert with love and determination, all other problems are readily surmountable. As noted by Magid and McKelvey (1988), the altruistic desire to ‘rescue’ a child from a difficult beginning is frequently the primary motivation behind adoption of institutionalized or maltreated children. Yet, even very selfless, highly motivated, adoptive parents, who are willing to make dramatic sacrifices to help deprived children, frequently end up disappointed by their children’s social and behavioral responses to their efforts. This reaction is exemplified by the comments of a mother of an orphan adopted at age 5 reported by Magid and McKelvey:

We spent more than 7 years trying to love this child’s hurt away. We exhausted ourselves and almost ruined our family. We virtually ignored our other children and spent all our time on Danny. Our family and friends didn’t understand the problem. They accused us of picking on Danny. When he got into serious trouble, like the time he vandalized our neighbor’s house, they wouldn’t press charges because they felt sorry for him. He caused more than $6,000 in damages! (1988, p. 93)

RAD was first recognized as a distinct disorder by the American Psychiatric Association in 1980 with inclusion of the diagnostic criteria in DSM-III. Subsequent DSM modifications to the original criteria for the disorder have focused on a later cut-off age of onset, removal of failure-to-thrive symptoms, and an increased emphasis on the role of psychosocial factors in the etiology. According to DSM-IV (1994), there are four criteria for the diagnosis. First, there must be significant, developmentally inappropriate disturbances in social relatedness in most contexts, with onset before age
5. Second, these disturbances cannot be associated with developmental delays caused by other problems or disorders. Third, a history of pathogenic care characterized by at least one of the following must be present: (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, or (3) repeated changes in primary caregivers. Finally, there must be a presumption that the social disturbances are a product of insufficient care. RAD afflicts 1 percent of the child population (Zeanah and Emde, cited in Richters and Volkmar, 1994). With the 1999 estimated US population of children (0–19 years) being over 78 million, 1 percent represents over 780,000 children who are potentially afflicted (US Census Bureau, 1999).

O’Connor et al. (1999) note that children with RAD have impairments related to social approach that manifest as an absence of understanding of interpersonal boundaries leading to inappropriate contact. Children with RAD are also unlikely to trust others and exhibit behavioral problems that are assumed to be a product of their inability to connect with others in positive ways (Groza and Rosenberg, 1998). Behaviors including tantruming, recklessness, risk-taking, bullying, stealing, abuse of pets, hoarding of food, and deception are recognized by practitioners and are often believed to be associated with RAD, but these problem behaviors are not currently considered part of the DSM-IV criteria (Groza and Rosenberg, 1998). In addition, children with attachment difficulties appear to have little or no remorse for their defiance and frequently seem to lack the capacity to form deep emotional relationships with others (Groza and Rosenberg, 1998).

A number of studies dating back to the 1940s have revealed socio-emotional, cognitive, and behavioral deficits in children raised in institutional settings. For example, these children have been found to exhibit superficial attachments to institutional employees, low IQ scores, dramatic acting-out, attention-seeking behavior, indiscriminant sociability, and clinginess (Goldfarb, 1945; Spitz, 1945; 1946; Tizard and Rees, 1975). RAD is believed to be caused exclusively by environmental factors, suggesting indirectly that reversal of symptoms might be possible with significant changes in the child’s immediate caregiving context.

Reactive attachment disorder and family dynamics

Although systematic exploration of family dynamics in homes with a child suffering from RAD has not been attempted, research has been conducted on typical patterns of responding to a physically ill family member. This work seems to have considerable applicability to the presence of a psychologically disturbed family member as well. According to Marvin (1992),
there are four primary patterns of family reactions to physically ill members: (1) activation of attachment-caregiver interactions, (2) loss of ‘executive power’ of the parenting subsystem, (3) decrease in spousal interactions, and (4) relieving the afflicted member from responsibilities and privileges. These patterns as applied to families with a child suffering from RAD are discussed in more detail below.

In the presence of an ill family member, others in the family, particularly the parents, tend to increase the intensity and/or frequency of caregiving behavior directed toward the sick individual (Marvin, 1992). Children suffering from RAD frequently have what seems to be an insatiable need for attention; therefore, when a child joins a new family, he or she is likely to immediately become the focus of attention and should evoke strong caregiving responses from the members. Nevertheless, there are child and parental factors that may introduce obstacles to the establishment of effective caregiver responses in adoptions involving children with RAD. For example, the unattached child brings well-established relationship schemata colored by feelings of being unworthy of love and affection and perceptions of others as incapable of meeting or unwilling to meet one’s needs (Bowlby, 1969; 1973). As noted by Cassidy et al. (1996), relationship schemata become increasingly resistant to change over time and may continue to direct an individual’s interactive behavior in pathological ways even with new interaction partners. As noted by Hayes (1997), children with RAD block internal and external signals that prompt them to give and receive love. Such defensive reactions provide protection from additional emotional trauma. With a lack of sensitive intervention, unresolved grief may lead to emotional numbing and an inability to positively connect to others.

Biologically based factors may also play a role in the aberrant social behavior of children with RAD. For example, Schore (1997) argues that early sensitively attuned interactive experiences result in neuronal pruning that is instrumental in the development of neurobiological pathways needed to foster adaptive affect regulation. The seemingly insatiable need for attention observed in children with RAD may represent a biologically driven effort to establish the neuronal connections necessary for adaptive regulation of emotions. More research is needed to examine the degree to which missed experiences can be compensated for at the neurological level by positive experiences occurring much later in development.

The need for attention expressed by children with attachment problems is likely to appear insatiable because caregiving responses from psychologically healthy adults are not readily received by children who have been significantly hurt by others in the past. As a result, parents are likely to feel ineffective and frustrated. More research is needed to clarify the types of
experiences with new caregivers that are most effective in terms of breaking down the barriers to intimacy with others that children suffering from RAD have often spent years developing. For example, what expressions of concern and love are likely to be believed by these children and in what situations? How is trust established when betrayal has played such a prominent role in these children's short lives?

Without a shared history with the later adopted child, biological children and/or previously adopted children may not respond in a doting way as Marvin's (1992) model would suggest, particularly if they begin to feel slighted or overlooked by their parents. Given the demanding nature of children suffering from RAD, it seems that even very well-meaning parents may actually end up neglecting other children in the home. Depending on the seriousness of the afflicted child's socio-emotional and behavioral difficulties, the quality of relationships between the child with RAD and siblings in the home may be compromised.

A second family pattern noted by Marvin (1992) is the loss of 'executive power' in the parental subsystem. Confusion about the course and possible treatment strategies associated with various illnesses in conjunction with elevated levels of stress often has a negative impact on parents' feelings of power in the role. Marvin notes that parental feelings of powerlessness or loss of control are frequently accompanied by enhanced feelings of power on the part of the sick individual. Parents of children with attachment difficulties may feel powerless to control their children's reluctance to develop substantive emotional bonds with them or to control negative behavior. Moreover, children with RAD often feel safe and free from fear and anxiety only when they are able to control others (Howe, 1998). For example, as noted by Howe, these children are likely to act out and provoke their parents to anger in order to feel they have won and that they are in control of their parents' emotional reactions. When parents are accepting of minor misbehavior, the child with RAD may up the ante and engage in conduct that is increasingly more inappropriate and distasteful to parents in an effort to get a response out of his or her parents. More research is clearly needed to identify the different tactics commonly employed by children with RAD to maintain control, and to identify specific strategies that can be implemented to reduce this need without detracting from the nurturing quality of the parent-child relationship.

According to Marvin's (1992) model, the third pattern frequently observed in families with a physically ill child involves decreased spousal interactions. Research by Rosenthal (1982) does suggest that adoption often causes significant strains on marriages. Decreases in spousal interaction do seem likely to emerge in families with children suffering from attachment problems because of the time and energy demands typically
made by children with RAD. One or both parents may simply feel too emotionally or physically drained from interactions with the child to put energy into the spousal relationship. If only one partner in a relationship is feeling exhausted by his or interactions with the child, then the other person may feel rejected. The desire to interact and maintain closeness remains in one partner but is not reciprocated by the other. This scenario seems particularly likely because one parent typically fulfills the primary caregiver role. To make matters worse, the ‘rejected’ spouse may begin to experience jealousy or hostile feelings directed toward the child, which could reduce the chances of establishing a positive attachment between this parent and the child.

A second reason for compromised spousal relationships in the presence of a newly adopted older child with attachment difficulties relates to possible negative perceptions of one’s partner. Adopting a child with RAD is likely to be extremely stressful and thus may provide ‘opportunities’ to see one’s partner at his or her worst. The testing behavior of children with attachment problems may provide a context for revealing, exaggerating, or developing responses or characteristics in one’s spouse that were not previously encountered. For example, if a child with an attachment problem harms the family’s pet, one parent may be provoked to rage. Such an uncommon event is unlikely to occur under other circumstances and may not be easily dealt with using one’s existing, more socially appropriate coping skills. Indeed, the individual experiencing the rage may be equally surprised and discouraged by his/her own behavior.

According to Marvin (1992), the fourth frequently described pattern in families with an ill child is the tendency to assign fewer responsibilities and tasks to the sick member. Others in the family are inclined to ‘take up the slack’ for the ill person because he or she is perceived as less physically able. With later adopted children there is another reason why parents may be less inclined to assign duties to a child with attachment problems and enforce completion of tasks. Specifically, because children with attachment difficulties are often motivated toward non-compliance in an attempt to incite the parent to anger and exert control, parents may be motivated to avoid battles and find it easier to either do the chores themselves or give them to a more willing sibling.

Siblings may be asked to do more by parents or they may take the initiative to do more on their own. A review of literature conducted by Lamorey (1999) led to the conclusion that there is increased psychosocial risk among siblings required to assume high levels of responsibility owing to the presence of a sibling with a physical ailment. Interestingly, a number of family process variables were found to mediate between exposure to heavy caregiving or household responsibilities and negative outcomes.
Specifically, sibling concerns about the future and perceptions of parental favoritism, family cohesion, and maternal negativity, depression, and anxiety were common mediators. These are all variables which may likewise mediate between increased family responsibilities on children with a sibling suffering from RAD and negative psychological or developmental outcomes. However, prior to investigating such processes, preliminary research is needed to examine the extent and nature of sibling overburdening in cases of RAD.

Effective assistance for families of children with RAD: a summary of existing knowledge and avenues for future work

When concern for the later adopted child with extreme attachment-related difficulties is addressed in the context of the above literature, a number of pressing research concerns are revealed. At the most basic level, more information is needed pertaining to fundamental attachment processes in children who miss environmental opportunities to develop such bonds. This entails an understanding of how negative experiences associated with unsuccessful efforts to gain emotional security might be overcome as well as establishment of a model for the development of adaptive attachments beyond the first few years of life. The essential question pertains to what interactive experiences, environmental supports, and internal attributes of the child enable later adopted children to forgive, forget, and ultimately learn to trust and love others. Attachment-promoting processes are likely to involve a complex interplay of corrective experiences with new caregivers coupled with diverse forms of family support in the schools and the wider community.

As noted by Winkler et al. (1988), clinical issues confronting adoptees are likely to include loss and trauma, rejection, guilt, shame, negative self-concept, low self-esteem, identity confusion, and isolation. Groza and Rosenberg (1998) recommend that clinical assessments with later adopted children address the question of whether the presenting problem is adoption-related, developmental, or represents an interaction of both. This is sound advice for researchers actively engaged in the study of later adopted children’s lives as well. In particular, minimal attention has been devoted to understanding interaction effects. For example, more significant problems might be expected with adoptees in adolescence when establishment of intimate relationships becomes a significant part of life. If issues pertaining to identity or to the self as related to others have not been dealt with earlier, children with RAD may develop increasingly complex artificial or fabricated
selves in an attempt to gain acceptance by peers. Dealing with emotional pain incurred prior to the adoption is a likely antecedent to establishing and developing new attachment bonds.

Under normative conditions, evidence that children are becoming attached involves recognition of family members as special people, expression of intense positive and negative feelings toward family members, expectations that family members will meet most of one's needs, and experience of empathetic feelings toward family members (Graham et al., 1999). Central questions remaining unanswered are whether or not these attachment indicators are even useful for describing later onset attachment behavior, and whether other more appropriate manifestations are likely to be observed. Relatedly, what skills and experiences are needed to promote attachment-related behavior? Are there developments, such as a well-defined sense of self, learning to comfortably relinquish control to others, or the ability to relax and enjoy the company of others, which need to be encouraged before gains in attachment can be expected?

Available research in the late adoption literature suggests that not all parents are equally predisposed to respond positively to an adopted child, with a number of parent-related variables having been examined as predictors of adjustment and positive relationships. Education about the limitations and special needs of these children seems to be a crucial factor. Available data indicate that parents who expect and are psychologically prepared to accept behavioral and emotional problems in adoptees seem to be more effective in terms of reaching these children (Simon and Sherwen, 1983). Being mentally prepared may facilitate a more patient and flexible orientation to parenting troubled children when they exhibit highly demanding, negative, unusual or awkward, and perhaps embarrassing behavior. Research suggests that informed expectations are linked with higher rates of attachment to the child and smoother assimilation of the child into the family (Fanshel, 1962; Gill, 1978).

Triseliotis et al. (1997) summarized additional adoptive parent and family factors associated with positive outcomes with adoptions involving older children. These variables included the following: absence of other children in the home, minimal pre-existing family stress, strong parental motivation, tolerance for differences, realistic expectations, an inclusive attitude toward the biological family, geographical proximity to relatives, a high frequency of church attendance, and a willingness to accept help from others.

According to Howe (1998), parents should be encouraged to establish clear rules and realistic expectations, to be proactive as opposed to reactive, to focus on identifying solutions rather than problems, to reinforce appropriate behavior, to cultivate a home atmosphere based on warmth, humor,
and mutuality, to be accepting and encouraging of children’s feelings, and to use consistent authorative parenting techniques. Howe also strongly recommends that these parents reach out to others for support and encouragement. Support may come from friends, relatives, and/or professionals. Many people derive emotional strength through religious practices, and studies suggest more favorable outcomes with later adoptions among regular church attendees (Howard and Smith, 1987; Nelson, 1985). Support groups may also be particularly helpful to parents of children with attachment problems. Adoptive parents of children with RAD frequently report that only parents who have children with similar problems can understand the daily challenges they face (Groza and Rosenberg, 1998). Groza and Rosenberg (1998) have noted that it is often the compassion and concrete suggestions from support group members that make the critical difference in preventing disruption of adoptions with children experiencing attachment difficulties. Support groups for families of children with RAD typically focus on dispensing of information, provision of advice, sharing of personal experiences, respite care, warmlines (phone support services), and other direct support services (Tremitiere, 1992; Trenberth, 1990).

Addition of a child with attachment disorder to the family has the potential to create considerable dysfunction in the family system. However, positive adaptation seems more probable when all parties are well versed about the disorder and parents, siblings, and others in the family are very committed to the goal of helping the afflicted child learn to trust others, and to experience emotions more appropriately and fully. Adaptive outcomes for all of those involved also seem predicated upon close contact with professionals and a healthy social support system.

Although much of our effort to provide appropriate care for our daughter has been based on what I consider ‘broadly informed intuition’, clearer professional guidance and understanding of the unique challenges we faced would have been greatly welcomed. My hope is that more focused research attention in this area will enable others, who are willing to grow with a child suffering from deep internal wounds inflicted from without, will be able to raise their children with fewer feelings of floundering frustration that we and many others like us have undoubtedly experienced.

References
COLEMAN: REACTIVE ATTACHMENT DISORDER

Background, Sample, and Procedure’, paper presented at the Meeting of the Canadian Psychological Association.

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Correspondence should be addressed to: PRISCILLA COLEMAN, Human Development and Family Studies, 16F Family and Consumer Sciences Building, Bowling Green State University, Bowling Green, OH 43403, USA. e-mail: pcolema@bgnet.bgsu.edu