CRB Training Module

Reactive Attachment Disorder
of Infancy or Early Childhood

Learning Objectives

After studying the information in this training module, you should be able to

- Identify the factors that put a child at high risk of developing Reactive Attachment Disorder

- Identify symptomatic behaviors of a child with the inhibited type of Reactive Attachment Disorder

- Identify symptomatic behaviors of a child with the disinhibited type of Reactive Attachment Disorder

- Identify recommendations that will help foster children with Reactive Attachment Disorder

Introduction

Approximately 80 percent of children who come from high-risk families suffer from attachment disorders. High-risk families include those whose lives include abuse and neglect, substance abuse, poverty, domestic violence, and mental illness. Attachment disorders result when a child's bonding with a caring adult is interrupted during the critical early stages of his or her life. Such children are not able to form meaningful emotional relationships; they may also show chronic anger and anxiety, poor impulse control, and a lack of remorse.

Origins of Reactive Attachment Disorder

Reactive Attachment Disorder begins during infancy and early childhood, always before age 5, although it can continue for many years. Children with Reactive Attachment Disorder have experienced one or more of the following as babies or toddlers:

- Their primary caregiver has persistently disregarded their emotional need for comfort, stimulation, and affection.

- Their primary caregiver has persistently disregarded their basic physical needs.

- They have had repeated changes of a primary caregiver that prevent them from being able to form stable attachments.

Young children are at high risk for developing attachment disorders if their environment includes substance abuse, teen parents, parents with depression or other severe and/or chronic psychological disturbances, poverty, and domestic violence. Children are also at risk who are

born prematurely, who have numerous hospitalizations, who have medical problems causing unrelieved pain, or have fetal alcohol syndrome, in-utero drug exposure, or physical handicaps.

Features of Reactive Attachment Disorder

Children with Reactive Attachment Disorder are markedly disturbed in their ability to relate to people. Their condition is considered a reaction to a terribly inadequate environment rather than a result of mental retardation, pervasive developmental delay, or autism. These children will appear either inhibited or disinhibited in their relationships with others.

> **Inhibited Type**: Children with the inhibited type of reactive attachment disorder either fail to initiate interaction with other people or they fail to respond appropriately to social interaction. They are excessively repressed and hypervigilant, and they resist comfort. They may respond to caregivers with great ambivalence, for example with frozen watchfulness or a combination of approach and avoidance.
>
> **Disinhibited Type**: Children with reactive attachment disorder who have the disinhibited type are excessively familiar and overfriendly with strangers. They are not selective about attachment figures nor do they discriminate among caregivers.

Other symptoms of attachment disorders, while not diagnostic, may also include the following:

> **Behavioral Symptoms:** oppositional and defiant behavior, lying and stealing, irresponsibility, cruelty to animals, hyperactivity, hoarding of food.
>
> **Emotional Symptoms:** intense anger, sadness, depression, moodiness, fearfulness, anxiety, irritability, and inappropriate emotional reactions. Infants may have a weak crying response or whine constantly.
>
> **Thought-Related Symptoms:** negative beliefs about the self, relationships, and life in general; lack of cause-and-effect thinking; attention and learning problems.
>
> **Relationship Symptoms:** lack of trust, manipulative behavior, bossy behavior, unstable relationships with peers, blames others for own mistakes. Infants will exhibit extreme resistance to cuddling; they will have poor eye contact and may not smile in response to being smiled at.
>
> **Physical Symptoms:** poor personal hygiene, enuresis and encopresis, accident prone. Infants may exhibit delayed physical motor skills such as creeping, crawling, sitting.

As with any childhood emotional or behavioral disorder, assessment and diagnosis of Reactive Attachment Disorder should be done only by a mental health professional, preferably one trained in children's mental health.

Outlook

Children with Reactive Attachment Disorder have an excellent chance of great improvement or remission if an appropriately supportive environment can be maintained. The length of time needed depends on individual circumstances such as how severe the early deprivation was and what kind of intervention is provided.

Corrective Attachment Therapy and other developmentally based attachment therapies have been shown to be more effective than traditional psychotherapeutic approaches that depend on ability to bond with a therapist. Therapy for children with attachment disorders will ideally involve a therapeutic relationship that can provide structure, empathy, support, safe containment, corrective touch, and the development of a secure base. Effective treatment will also address the various social systems in the life of the child and the family.

Implications for CRB Members

A large proportion of the children in the foster care system have been abused and neglected as babies or toddlers; thus many children reviewed by Citizen Review Boards show more or less severe symptoms of Reactive Attachment Disorder.

Children with Reactive Attachment Disorder need stable, continuously supportive environments with continuity in caregiver and other social relationships. They will often be frustrating for foster parents, CASAs, GALs, and social workers in their inability to accept comfort or to form close attachments. Frequent changes in foster care placement, in social workers, in therapists, and in schools will be particularly damaging to these children and should be avoided at all cost.

© New Mexico Child Abuse & Neglect Citizen Review Board, 2003

Sources: *DSM-IV*; and Attachment Treatment and Training Institute, Evergreen, CO, based on *Attachment Trauma and Healing* by Terry M. Levy and Michael Orlans (1998, Child Welfare League of America Press).

* * * * * * * *

If you are ready to take the test for this training module, click on the link below. Once you submit the test, your answers will be e-mailed to you and forwarded to Terri Newman for scoring.

Click Here to Take the Test