

Reactive Attachment Disorder of Infancy or Early Childhood

DSM-IV-TR Code: 313.89

Definition:

The term “attachment” is used to describe the process that takes place between infants and their care givers during the first two years of life, *but it is especially the bond that develops between an infant and his/her caregiver during the first nine to twelve months of life.* Mothers and babies engage in a series of interactions in which each is responding to cues from the other. The baby experiences discomfort or a need and protests usually by crying. The mother responds by picking the baby up, making eye contact, talks to and soothes the baby. In response the baby calms and trust develops and begins to interact with the mother and finally rests again before the cycle begins again as the baby experiences discomfort or a need. As this cycle is repeated thousands of times during the first year of a baby’s life, a securely attached relationship develops.

When a mother fails to respond, or responds inconsistently, the baby protests even louder. If his/her needs are not met, eventually the baby will give up and no trust develops and rage develops instead. Severely disturbed attachment cycles produce babies who are apathetic or who are forced to engage in self-stimulation, attempting to comfort themselves by compensating for the lack of their mother’s care.

Note: In this definition, “Mother” is representative of all caregivers. Clinical and anecdotal research has shown that infants also form strong emotional attachments to other caregivers, including fathers, foster parents, grandparents, adoptive parents, and so on. Additional research suggests that attachment is both a psychological and biological process that is rooted in an infant’s learning history and also influenced by intrapersonal characteristics such as temperament and sensory functioning.

Diagnostic Guidelines:

1. Establish diagnostic accuracy as defined in DSM-IV-TR
2. This diagnosis may be confused with Attention Deficit Hyperactivity Disorder, Separation Anxiety or Bipolar Disorder occurring in childhood, or there may be a co-occurring condition with any of the following disorders: ADHD, Bipolar Disorder, Fetal Alcohol Syndrome, Pervasive Developmental Disorder, Disruptive Behavioral Disorder. These disorders could be differentiated by using the Randolph Attachment Disorder Questionnaire (RADQ), a screening tool for children between the ages of 5 and 18 years.
3. The essential feature of Reactive Attachment Disorder is a markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathogenic care such as:

- a. persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection;
 - b. persistent disregard of the child’s basic physical needs; and/or
 - c. repeated changes of primary caregiver that prevent formation of stable attachments.
4. There are two primary types of presentation. First, there is the **Inhibited Type** where the child persistently fails to initiate and to respond to most social interaction in a developmentally appropriate way. Second, there is the **Disinhibited Type** where there is a pattern of diffuse and non-discriminant attachments. The child exhibits indiscriminate sociability or a lack of selectivity in the choice of attachment figures. The disturbance is not accounted for solely by developmental delay (as in mental retardation) and does not meet criteria for pervasive developmental disorder. By definition the condition is associated with grossly pathological care that took the form of persistent disregard of the child’s basic emotional needs, physical needs or repeated change of primary care given that prevented formation of stable attachments.
 5. Presence of cognitive problems such as inability to organize information so as to see cause and effect relationships.
 6. Occurrence of pathogenic care in form of severe and persistent emotional and/or physical neglect or repeated changes of primary caregiver where attachments were prevented from forming. Pathogenic care occurred before onset of symptoms indicating disturbance in relatedness.
 7. In order to determine range of severity, evaluate for:
 - Securely attached children – (would not warrant diagnosis)
 - Insecurely attached children
 - Avoidant children
 - Disorganized attachment in children
 8. When 5 and 6 are present, consider the presence of many of the following symptoms in making a diagnosis:

<u>Social</u>	<u>Emotional</u>	<u>Behavioral</u>	<u>Developmental</u>
Superficially engaging and charming child.	Indiscriminately affectionate with strangers.	Destructive of self, others, things.	Experiences developmental lags.
Will not make eye contact.	Not cuddly with parents.	Cruel to animals, siblings.	Lacks cause and effect thinking.
Has poor peer relations.	Is inappropriately demanding or clingy.	Engages in stealing, lying.	Lacks a conscience.

Engages in persistent nonsense questions or incessant chatter.		Has poor impulse control.	Has abnormal speech patterns.
Fights for control over everything.		Engages in gorging on food.	
		Has a preoccupation with fire, blood or gore.	
		Encopresis or enuresis	

9. Further symptoms of insecure attachment in children and adults are as follows:

SYMPTOMS OF INSECURE ATTACHMENT

IN CHILDREN...

- superficially charming or phony
- manipulative
- affectionate to strangers
- lack of eye contact
- aggressive behavior
- hyper-vigilant
- resistant to parental affection
- steals, lies, hoards food
- persistent nonsense questions and incessant chatter
- oppositional, fights for control over everything, demanding
- impulsive and inattentive
- lack of cause and effect thinking
- preoccupied with fire, blood, violence
- cruelty to people/animals
- destruction of property
- lack of or little remorse or empathy
- poor mood regulation
- poor social skills/peer relationships
- separation anxiety

IN ADULTS...

- controlling/manipulative
- impulsive
- socially inappropriate behavior
- seductive/provocative behaviors
- inappropriate anger
- unrealistic demands/expectations
- unstable moods
- unstable relationships

- self-mutilating behaviors
- shallow/vain
- lack of empathy or remorse
- self-importance
- grandiose fantasies
- feelings of entitlement or arrogance
- feelings of being special/unique

ATTACHMENT THERAPY (PEACHTREE ATTACHMENT RESOURCES, L.L.C.)

Attachment Therapy is individualized treatment that focuses on treating and respecting the whole individual. It builds on the individual's strengths, and individual and family members are active participants in the therapeutic process. Attachment Therapy focuses on reciprocal relationships, so all of the relationships in the family are valued by the therapist(s). This allows treatment to extend to the parental/marital couple relationship, the parent-child relationship and the sibling relationship. Treatment also takes into consideration all past and present family dynamics.

Treatment Guidelines

1. Treatment consists of a process which may include:
 - a. Development of sensory and affective experience and expression.
 - b. Cognitive and behavioral therapy is effective in relearning appropriate expression of feelings and needs and to contain conduct problems.
 - c. Relationship therapy is effective in repairing trust and in developing a sense of belonging to the family.
 - d. Loss and grief work is seen as an essential part of treatment.
 - e. The goal of Family therapy is to repair a child's attachment process by encouraging nurturing from the caregiver through a behavioral approach.
 - f. Eye Movement Desensitization and Reprocessing (EMDR). See the Colorado Health Networks guideline on EMDR.

2. Refer for medication/evaluation if:
 - a. Thought disorder is evident in the child.

- b. The child has wide mood swings resulting in persistently dangerous behavior to self or others.
 - c. Attention problems are significantly interfering with academic performance.
3. CHN and the Colorado State Statute prohibit the use of holding therapy as an approved technique.

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