Reactive attachment disorder in children: Impacts on development, educational implications and the need for secure attachment

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Abstract
The early years of a child's life are regarded as the most important, in the sense that encounters within infancy tend to influence the child's maturation. 'Attachment' is regarded as a prime contributor to the success or inhibition of child development, making it a vital component of child–caregiver interactions. This paper highlights the detrimental consequences that insecure attachment can have upon the maltreated child and their personal development through focusing on reactive attachment disorder (RAD). RAD is recognised as a clinical disorder that limits the child's social abilities, emotional regulation and cognitive function. Throughout this paper, RAD will be explored in terms of origin, characteristics, implications and educational implications for children with the disorder, which will be framed within Bronfenbrenner’s Bioecological Model of Human Development. In accentuating the deleterious factors stemming from RAD, and ultimately insecure attachment, the need for secure attachment is implied.

Keywords
reactive attachment disorder, attachment, Bronfenbrenner, Bioecological Model of Human Development, educational implications, child development, RAD

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Reactive attachment disorder in children: Impacts on development, educational implications and the need for secure attachment

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The early years of a child’s life are regarded as the most important, in the sense that encounters within infancy tend to influence the child’s maturation. ‘Attachment’ is regarded as a prime contributor to the success or inhibition of child development, making it a vital component of child–caregiver interactions. This paper highlights the detrimental consequences that insecure attachment can have upon the maltreated child and their personal development through focusing on reactive attachment disorder (RAD). RAD is recognised as a clinical disorder that limits the child’s social abilities, emotional regulation and cognitive function. Throughout this paper, RAD will be explored in terms of origin, characteristics, implications and educational implications for children with the disorder, which will be framed within Bronfenbrenner’s Bioecological Model of Human Development. In accentuating the deleterious factors stemming from RAD, and ultimately insecure attachment, the need for secure attachment is implied.

Keywords: reactive attachment disorder; attachment; Bronfenbrenner; Bioecological Model of Human Development; educational implications; child development; RAD

Introduction

Development is an inescapable and ever-growing component of humanity that operates on a multifaceted level, inclusive of cognitive, social and emotional categories. There are multiple factors that influence the efficiency and effectiveness of development making it a process of precision. Specifically, child development is integral to predict the future behaviours, personality and intelligence of the child and, thus, a substantial amount of emphasis is placed on elements that contribute to the maturation of a child which, ultimately, mould their adolescence. In child development, a key principle known as ‘attachment’ has surfaced and it is this process that is actively involved in the success or inhibition of development within the child (DeMulder et al., 2000). While secure attachment between the child and another can pave the way for successful cognitive, social and emotional development, insecure attachment can produce detrimental results for the child in these areas. Reactive attachment disorder (RAD) is a potential consequence of insecure attachment that ultimately affects the child’s ability to socially and emotionally engage with others, while also having a substantial impact on cognitive ability. While RAD has many unsolved mysteries, its causes and effects on development and educational
implications remain well-researched and, through this, the importance of early, secure attachment within children is heightened.

**Reactive attachment disorder (RAD)**

‘Attachment’ is a term used to describe the intricate connection of affection that binds a child to their primary caregiver on a psychological level (Ainsworth & Bell, 1970; Bowlby, 1969). This concept can be dated back to the works of John Bowlby and Mary Ainsworth and their collaboration in the formation of attachment theory (Ainsworth & Bell, 1970; Bowlby, 1969). Through the combination of developmental psychology, ethology and evolution, Bowlby highlighted the significance of secure proximity between an infant and primary caregiver and how, when the infant is deprived of such proximity, a state of disorder arises within the child–caregiver relationship (Bretherton, 1992). Through the evolutionary perspective, Bowlby proposed that infants expressed attachment behaviours, such as crying and clinging, toward their primary caregiver to signal an unfulfilled need (Bowlby, 1969). The primary caregiver, in turn, feels responsible for resolving this need and, thus, attachment is formed (Kennedy & Kennedy, 2004). One particular proposition made by Bowlby is central to this paper – the neglect of such attachment behaviours, and ultimately the infant’s needs, results in deprivation toward the child as well as a state of disorder within the infant–primary caregiver relationship (Bowlby, 1969).

RAD is identified as a severe impairment of social relationships and functioning (Pritchett et al., 2013) and has been positively correlated with experience of insecure attachment types (Minnis et al., 2009). While insecure attachment between child and caregiver may increase the child’s risk of developing psychosocial difficulties, not all children with insecure attachment develop RAD (Hanson & Spratt, 2000). According to Richters and Volkmar (1994), cases of children who have experienced insecure attachment at the hands of pathogenic care have surfaced, however, a relation to RAD was not explicit. This paper, however, will focus on those who have been diagnosed with RAD or have exhibited RAD behaviours as a result of insecure attachment and pathogenic care. Two variants of the disorder have been identified. Inhibited RAD accounts for a child who is detached socially and emotionally, is resistant toward affection and does not display emotion easily (Gleason et al., 2011; Pritchett et al., 2013). Disinhibited RAD includes the child displaying ‘indiscriminant sociability’ (Gleason et al., 2011), that is, the child is not highly selective in their choice of attachment figures and is more likely to express attachment and friendliness toward a stranger than their own primary caregiver (Gleason et al., 2011; Pritchett et al., 2013).

**Characteristics**

The question of addressing the two distinct types of RAD as separate disorders is prominent within this area of research, however, this paper will adopt the position of the DSM-IV (American Psychiatric Association, 1994), in conceptualising RAD as holistic and including both variants. RAD is usually developed before the age of five and may be recognised as early as in the first month of life (Richters & Volkmar,

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1 Where the child’s basic emotional, physical and/or psychological needs are not met, whether through disregard or repeated changes in caregiver (American Psychiatric Association, 1994).
1994). In addition to the briefly outlined attributes that distinguish the ‘inhibited’ and ‘disinhibited’ forms of RAD, this attachment disorder is seemingly laden with a plethora of features that impact the child’s sociability. Maladaptive behaviours are prominent within children diagnosed with RAD which make basic social interactions a challenge or non-existent for these individuals. In a study conducted by Mukkades et al. (2000), the symptoms of RAD were examined among a sample of 15 (nine boys, six girls), with a mean age of 31.4 months. The prevalence of symptoms was also observed and provided a detailed insight into the signals of RAD in children. Through this study it was found that 80% of the sample showed restricted eye contact, 0% reflected an interest in people, 0% searched for playmates and 66.7% expressed hyperactive behaviour (Mukkades et al., 2000). Parker and Forrest (1993) also compiled a list of characteristics of children diagnosed with RAD, including: cruelty to others, inclusive of pets; being engrossed in gore, blood and fire; and engagement with a concept known as ‘crazy lying’, in which the child lies despite knowing the other person is aware of the truth.

**Catalysts**

While much controversy has surrounded RAD and its similarity to other disorders such as autism spectrum disorder and attention deficit/hyperactivity disorder (ADHD), the one outstanding differentiation between them is the prominence of pathogenic care. Pathogenic care is described as a primary caregiver’s persistent neglect and dismissal of the child’s physical and emotional needs, encompassing that of comfort and affection (Dahmen et al., 2012; Schwartz & Davis, 2006). Wiik et al. (2011) found that of a group of 68 post-institutionalised children in middle school, aged 8–11 years old, 22% expressed ADHD symptoms rather than pure ADHD. This finding, therefore, suggests that ADHD may not directly result from pathogenic care. Symptoms associated with ADHD are prevalent, however, which also heightens the large percentage of misdiagnoses between RAD and ADHD as well as their similarities. Dahmen et al. (2012) built on such a finding and illustrated the distinction between pathogenic care causing pure ADHD and causing ADHD-like behaviours. They concluded that those exposed to early pathogenic care and exhibiting ADHD-like behaviour were different from developing pure ADHD due to the fact that not all the criteria for ADHD were fulfilled or these children exhibited behaviours that are not representative of pure ADHD, such as indiscriminant friendliness (Dahmen et al., 2012).

The characteristics of pathogenic care, according to Dahmen et al. (2012), are inclusive of the continual change in primary caregivers. In a study conducted by Smyke, Dumitrescu and Zeanah (2002), correlations between depriving environments and patterns of disordered attachment were investigated. Three categories of children were observed in the study: (1) 32 children aged 4–68 months living in a standard care unit in a large institution in Romania (ST group); (2) 29 children aged 18–70 months living in the same institution under a pilot care unit (PI group); and (3), 33 toddlers aged 12–47 months who had never been institutionalised (NI group) (Smyke, Dumitrescu & Zeanah, 2002). The study was conducted through interviews with the primary caregivers of the children and responses were rated on a three-point scale (Smyke, Dumitrescu & Zeanah, 2002). The results reflected that children in the ST group expressed more signs of disorganised/disordered attachment than those within
either the PI or NI groups, resulting from the children being unable to predict the presence of their apparent preferred caregiver in such a setting due to staff scheduling (Smyke, Dumitrescu & Zeanah, 2002). The ST group also provided the highest scores on the RAD inhibited/withdrawn scale, heightening the connection between insecure attachment and the potential to develop RAD (Smyke, Dumitrescu & Zeanah, 2002). It was also found that children who had not been institutionalised (NI) expressed very few behaviours associated with RAD (Smyke, Dumitrescu & Zeanah, 2002). This study, thus, provides evidence that a continuum of caregiving exists, and where a caregiver falls on this continuum has a significant impact on the child’s potential development of RAD.

Some implications
Through the extensive research conducted on RAD, a number of implications existing across the clinical sector have become increasingly evident. With recognition of RAD as a serious disorder, it is integral that accurate diagnosis is given in order to focus on the most appropriate and beneficial treatment methods for the child (Sheperis, Renfro-Michel & Doggett, 2003). In a study conducted by McLaughlin, Espie and Minnis (2010), a ten-point observation schedule was made specifically for school-aged children aged 5–8 years, in an attempt to assist clinicians in the diagnosis of RAD, as it is both over and under diagnosed which, in turn, can lead patients in a non-beneficial direction in terms of treatment. Due to the common misdiagnosis of RAD, the necessity for efficient diagnosis is accentuated. Accurate diagnosis is integral for children and caregivers to seek out the appropriate treatment and advice to manage the child’s situation.

While RAD is an independent disorder, studies have accentuated the highly likely possibility of comorbidity. Comorbidity is defined as the simultaneous occurrence of two or more disorders or diseases (Hanson & Spratt, 2000). The DSM-IV-TR (American Psychiatric Association, 2000) outlines an underwhelming list of symptoms associated with RAD (Stinehart, Scott & Barfield, 2012) and, ultimately, fails to express the broad range of characteristics that, depending on the child, range in intensity (Stinehart, Scott & Barfield, 2012). In doing so, the DSM-IV-TR (American Psychiatric Association, 2000) also fails to detail the similarities of RAD symptoms with those of other disorders, such as ADHD and conduct disorder, a key overlooked issue that can lead to under diagnosis. Dozier et al. (1991) drew connections between insecure attachment and increased susceptibility to developing a psychiatric disorder. They found higher levels of insecure and dismissing-avoidant attachment in their psychiatric sample, which consisted of 40 adults aged 21–51, in comparison to their non-psychiatric sample, consisting of 40 adults aged 42–46 (Dozier et al., 1991; Kobak & Hazan, 1991). This study highlights psychiatric illness as a top contender for being classified as comorbid with RAD. While pathogenic care is a defining component of RAD etiology, it does not rid the child of the possibility of developing comorbidity (Stinehart, Scott & Barfield, 2012).

The Bioecological Model of Human Development
The primary caregiver’s role is central to the establishment of a successful or detrimental proximity, however, the Bioecological Model of Human Development, while still valuing this concept, extends its barriers to cover the contextual factors that
influence the relationship to be the way that it is. This model, proposed by Urie Bronfenbrenner, captures how the characteristics of individuals and the context of occurrence greatly influences proximal processes (Tudge et al., 2009). The key component of this model lies within the PPCT framework (Process–Person–Context–Time). The development of RAD can be placed within this PPCT framework to further accentuate the role of the environment and the biological individual, and their contribution to successful or detrimental attachment.

**Process**

The *process* component of the model refers to face-to-face interactions that form the basis of and catalyse development (Bronfenbrenner & Morris, 2006; Tudge et al., 2009). In relation to attachment, *process* is simply the human–human interaction that occurs when the primary caregiver responds to his or her distressed child (Bronfenbrenner & Morris, 2006). In the instance of RAD, however, there is limited or no interaction between caregiver and the child in need. This comparative neglect, in turn, influences the *person* who is, in this case, a maltreated child.

**Person**

Bronfenbrenner (2005) placed significant emphasis on the individual characteristics each human possesses and the way in which they surface, given a specific social context (Bronfenbrenner, 2005; Tudge et al., 2009). Within these characteristics is the notion of the child forming an expectation of their primary caregivers due to the recognition of similar characteristics, such as sex and skin colour (Tudge et al., 2009). In the instance of RAD, the caregiver has neglected this innate expectation and thus, the beginnings of a hindered attachment are fostered. In relation to the school context, as the RAD child matures, the results of this insecure attachment become evident in the child’s lack of motivation and drive to succeed.

**Context**

*Context* refers to the person’s operation within one of the four proposed ‘systems’ by Bronfenbrenner: microsystem, mesosystem, exosystem and macrosystem ( Bronfenbrenner & Morris, 2006). The microsystem refers to the child’s immediate environment with which they have direct contact; the mesosystem serves as a tool that creates links between the facets of the microsystem; the exosystem is comprised of facets that indirectly impact the development of the child, such as parental employment; the macrosystem is comprised of the societal values and norms, cultural beliefs and political trends that influence the other systems (Swick & Williams, 2006). For RAD children, their involvement with each of these systems is inextricably linked with the process of maltreatment. A child with RAD would have experienced maltreatment within the home environment (microsystem), with possible linkage to causes in the exosystem, which has a direct impact on their social interactions and academic capacity at school (mesosystem).

**Time**

A stable environment has the power to influence child development (Bronfenbrenner & Morris, 2006). A subcategory of *time*, known as ‘microtime’, is the portion of time that deals with the stability and instability present in *process* (Bronfenbrenner &
Applying this to RAD can be seen in the way that RAD children typically have unsettling, disjointed living conditions and arrangements, specifically, infants within the foster care system. These children experience discontinuity in the way that their primary caregivers are constantly swapped and they are continuously placed within foreign home environments. This instability can be noted as a catalyst for insecure attachment and pathogenic care that leads to the development of RAD.

**Educational implications**

Education is one of the most fundamental elements that impact a child’s development in terms of cognition, sociability and emotion (Burger, 2010; Lee, 2013). In the case of children with RAD, this educational experience is disrupted by the child’s lack of trust and social skills. Interactions with others, perceptions of self and academic capabilities are tarnished in the process.

**Socio-emotional**

Schemas are complex mental networks that organise and link related pieces of information into logical categories (Arnold, 2010). A maladaptive schema is described as the distorted mental connections between certain concepts and figures based on an individual’s experience (Kellogg & Young, 2006). The foundation of the student–teacher relationship is the child’s schematic knowledge about the basis and operation of social interaction (Davis, 2003). In the case of RAD children, their prior encounters with maltreatment may have been accommodated into their schematic knowledge and thus, upon transitioning into the primary stages of schooling, the teacher, who acts as a caregiver for the students, is met with an unemotional and unresponsive student. This distortion of the concept of ‘caregiver’ parallels issues with ‘basic trust’ – the notion where a child recognises a nurturing caregiver who will always be available to help in times of distress (King & Newnham, 2008). A child’s early experiences which are identified as disruptive and chaotic, such as the pathogenic care experienced by those with RAD, equates to the child failing to form accurate knowledge and expectation of what it is to be nurtured by a caregiver and, thus, trust is absent or limited within the child (King & Newnham, 2008). This distrust ultimately manifests and is projected toward other individuals, becoming detrimental to the student–teacher attachment. Children with RAD are unable to cope with restrictions placed on them from an authority figure (Sheperis, Renfo-Michel & Doggett, 2003). This is of particular concern in a classroom setting, in the way that numerous rules are placed upon the children for safety and disciplinary purposes – resistance to complying with these may heighten RAD behaviours. On the opposite end of the RAD spectrum, disinhibited RAD children may actually reflect greater dependency on their teacher (Kobak et al., 2001).

Due to an inability to socialise in a way that adheres to the norm, RAD children are susceptible to victimisation. Raaska et al. (2012) noted that children, aged 9–15, with RAD reported three times more accounts of bullying than non-RAD children. Further, the victimisation was a result of the RAD children’s poor social skills as well as evident learning difficulties and relatively low levels of communication skills (Raaska et al., 2012). These social impairments experienced by RAD children manifest into further complications associated with emotional development which, in turn, place strain on the child’s educational experience.
Secure attachment between child and caregiver assists the regulation of emotional and arousal states (Schore, 2001). This regulation allows the child to coherently respond to and cope with emotional and arousal regulation in high-stress situations (Schore, 2001). Self-regulation is a core attribute necessary for the efficient functioning within a school environment in the presence of other children (Schwartz & Davis, 2006; Sroufe, 2000). The ongoing battle between opposing demands of gratification and the incapacity for emotional and self-regulation leads RAD children into states of anxiety, including low self-esteem and self-loathing (Schwartz & Davis, 2006).

**Cognitive**

Given the myriad of social and emotional impacts that RAD has on the child, there is an interconnected effect on cognition. The apparent distinction between RAD and non-RAD children inculcates RAD children with low self-worth (Pritchett et al., 2013; Schwartz & Davis, 2006). This has a reciprocal effect on the children’s academic motivation, decreasing it in an environment that should be enriching children’s drive to succeed. Kocovska et al. (2012) studied the impact of early maltreatment of children on neurodevelopment. In the study, 66 children, aged 5–12, were observed, 34 adopted with a history of maltreatment before adoption and 32 children with no history of maltreatment and living with their biological families (Kocovska et al., 2012). Through a battery of tests, such as the Wechsler Abbreviated Scale of Intelligence and the Renfrew Language Scales, it was found that the scores of the adopted/maltreated sample were significantly lower than that of the other sample (Kocovska et al., 2012). Specifically, the adopted/maltreated sample reflected a mean IQ that was 15 points lower than the comparison sample (Kocovska et al., 2012). A prevalence of language disorders and delay were evident amongst the adopted/maltreated group (Kocovska et al., 2012), which added to the children’s cognitive hardship. In this case, intelligence testing, while controversial, has provided an insight into the impact of maltreatment on a child’s neurodevelopment and how it may minimise the chance for academic success.

Weinberg (2010) similarly drew links between early childhood maltreatment and neurobiological alterations through a case study of a 12-year-old female who was diagnosed with disinhibited RAD. This same child was diagnosed with a non-verbal learning disorder, which can be related to disturbances impeding on the brain’s right hemisphere (Dool, Fuerst & Rourke, 1995; Weinberg, 2010). Dool, Fuerst and Rourke (1995) expand on this, stating that right-hemispheric function specialises in the processing and execution of novel information and tasks. Infringements, therefore, such as a history of abuse or maltreatment, can burden right-hemisphere functioning and increase the possibility of developing further learning disabilities, such as non-verbal learning disorder, in addition to RAD (Dool, Fuerst & Rourke, 1995; Weinberg, 2010). A child with insufficient right-hemisphere functioning, therefore, can have great difficulty in trying to grasp foreign ideas and concepts proposed in the classroom (Dool, Fuerst & Rourke, 1995), leaving them cognitively impaired to an extent that affects their school functioning.
Conclusion
Given the nature and influence of its existence, RAD is a concerning impairment on sociability, emotion and cognition. While RAD is regarded as a rare and relatively new disorder, its influences on aspects of child development are not as under-rated. Through the study of the precursors and consequences of RAD, secure attachment between an infant and their primary caregiver is recognised as crucial in assisting successful and coherent development within the child. Confirmation of the severity of RAD is evident through investigations, illustrating its placement of limitations on children’s human–human interactions, negatively geared emotional states and regulation and the link between maltreatment and cognition. This paper offers insight into the lives of RAD children, shedding light on their prior and current circumstances, their interpretations of certain situations and the way RAD influences their behavioural actions and reactions. The direct and indirect external factors that influence the development and exhibition of RAD are also heightened in placing it within Bronfenbrenner’s bioecological model. Despite the information provided throughout the paper, RAD remains a disorder that is largely uncovered. The evolution of knowledge associated with RAD, starting from the likes of Bowlby and Ainsworth, is evident throughout research, however, unanswered questions remain. Current research holds the promise of gradual future revelations of this currently underemphasised disorder, which can impact parenting and child development.

References


