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Reactive Attachment Disorder in Adopted and Foster Care Children: Implications for Mental Health Professionals

Michelle A. Stinehart¹, David A. Scott¹, and Hannah G. Barfield¹

Abstract

A disruption in the initial attachment formed between an infant and a primary caregiver often leads to some type of disordered or disorganized attachment. While research has been conducted on the etiology, symptoms, and effective forms of therapy regarding this disorder, much definitive information remains unknown or unclear. With the increasing use of foster care in America and the frequency of adoption, it is becoming obvious that more attention is needed in the area of how to best appropriately approach a diagnosis of reactive attachment disorder. This article will discuss current trends and implications for mental health professionals working in the field of foster care and adoption settings.

Keywords

attachment style, foster care, adoption, reactive attachment disorder

Many children entering into adoption and foster care services will need to be properly evaluated to help the family deal with any presenting mental health issues. Reactive attachment disorder (RAD) is still considered a relatively new diagnosis. RAD is a more extreme psychiatric diagnosis for a subgroup of children with the most significant and detrimental insecure attachments (Tobin, Wardi-Zonna, & Yezzi-Shareef, 2007). Recent research (Millward, Kennedy, Towlson, & Minnis, 2006) supports previous findings that children in residential placements have a significantly higher risk of mental health problems than children not residing in residential placements. The U.S. Department of Health and Human Services (2009) reported that there were over 460,000 children in foster care placement in 2008. In 2009, Office of Children’s Issues (2011) reported that American families adopted approximately 12,700 children from other countries (down from 22,000 in 2004). Lake’s (2005) research indicated that between 38–40% of toddlers who experienced poor care giving and were removed from their parents’ home show signs of RAD. This suggests that with the growing number of children in the foster care system and the growing number of children who are adopted internationally from subpar orphanage care, we may see a rise in the frequency of this diagnosis.

The Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision; DSM-IV-TR; American Psychiatric Association [APA], 2000) emphasizes that not every child living in an environment of maltreatment or pathogenic care will develop RAD. Children may develop appropriate and stable relationships in their social circles or with other supporting adults and can develop normally even in the absence of a stable primary caregiver. The DSM-IV-TR (APA, 2000) also notes that the evidence of this disorder must begin before the child reaches the age of 5. The course of this disorder seems at least somewhat dependant on individual differences in both the child and the caregivers. If placed in a more appropriate environment of support and stability, a child could show significant improvements. Typically, however, RAD follows a continuous course and the symptoms may persist even when a child is able to develop appropriate attachments (APA, 2000).

In the early stages of development, even before birth, a fetus begins to form an attachment to the woman carrying it. After birth, an infant will display an almost biological need to attach to a primary caregiver, typically a mother; in a healthy relationship between a parent and child, this attachment continues to build. It is consistently strengthened as a child is comforted when scared, fed when hungry, and in general is made to feel safe and secure. An infant will seem to seek an unbroken gaze into the caregiver’s eyes and may attempt to mirror the caregiver’s facial expressions; both of these behaviors lead to positive affect and further attachment and bonding in infancy (Corbin, 2007). Attachment theory states that normal, healthy

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emotional development can only occur in an infant when an attachment is formed with a primary caregiver who is consistently responsive to the infant’s need to be fed, comforted, and nurtured (Wimmer, Vonk, & Bordnick, 2009).

For various reasons, a child may be robbed of the experience of developing the healthy attachment with a primary caregiver that is described above. These reasons could include institutionalization at an orphanage, entering foster care, or experiencing neglect or abuse from a caregiver. In some instances, the healthy attachment that is being established is suddenly disrupted causing further emotional complications. Any child experiencing a disruption in the normal developmental patterns of healthy attachment may be at risk of developing disordered or disorganized attachment (Becker-Weidman, 2008).

While some mental health professionals assert that the etiology of this diagnosis is still largely unknown, most confidently believe that RAD begins with some level of disruption between the intimate and exclusive relationship between a caregiver and child (Lake, 2005). More simply, the etiology of RAD involves some level of pathogenic care toward a child (Corbin, 2007). This can include isolation from or lack of a caregiver, which is often seen in orphanage settings and abusive environments where the caregiver is a perpetrator or shows lack of concern or ability to keep the child safe. There is also a less prevalent indication that severe, chronic pain in infancy or childhood could also be an antecedent of this diagnosis (Hall & Geher, 2003); however, for the purpose of this article, the focus will remain on maltreatment or pathogenic care as the etiology.

RAD can vary greatly from one child to the next. The focus will be on the two subtypes described in the *DSM-IV-TR* (APA, 2000). The first of these subtypes is called emotionally withdrawn or inhibited pattern of RAD; in short, a child with this pattern would exhibit very minimal or no attachment behavior, even at times where this would be appropriate and expected. A child with this diagnosis may show the absence of reciprocity of emotions or difficulty regulating emotions in general. The child may also exhibit a lack of ability to engage socially and may not seek comfort even when in a state of high arousal or distress (Zeanah & Smyke, 2008). The diagnosis of this subtype may relate back to the child’s lack of a consistent primary caregiver. Their history would likely tell of gross neglect and a consistent severe lack of affection and attention (Lake, 2005).

The second clearly defined subgroup of this disorder is known as the indiscriminate or disinhibited type. A child exhibiting this pattern would consistently fail to show developmentally appropriate reserve around unknown adults. For example, the child engages socially with strangers with little or no reticence, possibly wandering from the primary caregiver with no need or intention to check back in. The child could even display a willingness to leave what may be a safe area with a stranger (Zeanah & Smyke, 2008). They may also deliberately approach a complete stranger to ask for help or to seek physical comfort or affection (Lake, 2005). Typically, a healthy developing child will begin to develop hesitancy about strangers in the latter part of their first year of life. Some degree of this feeling should remain present in every normally developing child, regardless of age. While there is certainly an allowance for individual differences in a child’s personality, a child with this diagnosis would display an abnormal lack of wariness toward strangers (Zeanah & Smyke, 2008).

There are several other diagnoses that display disordered attachment and may share some of the symptoms described above. This seems to be particularly true of a few developmental disorders, including Williams syndrome and pervasive developmental disorders. The primary difference between these disorders and RAD is in their etiology. These particular developmental disorders and related behaviors are often present in an environment of adequate and even excellent care giving. A required diagnostic criterion for RAD is some level of pathogenic care such as neglect, abuse, or repeated disruptions in or changes of the primary caregiver. The *DSM-IV-TR* (APA, 2000) diagnostic criteria for RAD also include eliminating the possibility of a diagnosis of a developmental disorder or of a pervasive developmental disorder.

Children diagnosed with RAD may show a number of symptoms beyond just their inability to display appropriate attachment. These symptoms can even surface before the child’s first birthday. A few of these early warning signs are difficulty being comforted, failure to gain weight, severe colic or feeding difficulties or unresponsive behavior that is considered atypical for an infant. As the child grows older, they may also show unusual behaviors toward the consumption of food, which may stem from the gross neglect they experienced. This may include food hoarding, gorging, or even eating foods with little or no nutritional value such raw flour or paper. They may continue to show a lack of impulse control or empathy. As a teenager, they may display extreme mood swings, temper tantrums, depression, and issues with inattentiveness (Lake, 2005). In some extreme cases, an older child may also engage in criminal behaviors such as stealing, the destruction of public property, violence toward others, and cruelty toward animals but show no signs of regret or remorse. These antisocial behaviors seem to lie in the child’s inability to grasp “cause-and-effect thinking” (Hall & Geher, 2003, p. 147). There is some indication that the more violent behaviors may be seen in the group of children diagnosed with RAD who, more specifically, experienced some level of physical abuse or violence in their formative attachment phase (Hall & Geher, 2003).

**Children Adopted and in Foster Care**

While this disorder is not at all unique to children who are adopted, this does appear to be a serious at-risk group. There is research that indicates an adopted child may have more psychological and behavioral issues and be more at risk of a diagnosis of RAD than a child raised by a biological parent (Hall & Geher, 2003; Millward et al., 2006). Strickert (2004) reported that RAD is one of the top five health problems with children who are adopted internationally. Many children who are adopted internationally may have spent time in an institution-style orphanage with an abundance of children in need of care with a serious shortage of available caregivers. These children
may have lacked the opportunity to bond with a primary caregiver or may have experienced a disruption in their bonding that comes with a frequent change in caregivers. Wingert and Nemtsova (2007) suggested that this appears to be especially true of children adopted from Eastern Europe. For a small but notable percentage of these children, the adjustment to this new life does not occur smoothly; this is often thought to be due to attachment issues (Institute for Attachment & Child Development, 2011).

This can be particularly jarring for the involved family because they may not have been adequately prepared by their agency for these potential emotional and behavioral issues. In addition to this, an adoptive family is often eager to hurriedly form a strong bond with a child for whom they have been patiently waiting. In the instance that this child is unable to appropriately accept this affection, it can be frustrating and even frightening for all the parties involved. Some children with RAD can also display significant behavioral issues, which can be highly disruptive to the previously healthy family unit. Further complicating this issue is the ongoing struggle with some of the internationally adopted children not having their mental states fully assessed before the adoption occurs (Institute for Attachment & Child Development, 2011). This can result in a bewildered family learning that their healthy child actually has significant issues. There are reports of a growing number of adoptees being resigned to the American foster care system after their exhausted parents are unable to care for their extensive needs any longer (Festinger, 2002). While these cases are extreme, they are indicative of the level of helplessness and frustration a family can feel when dealing with RAD. In an attempt to combat these issues, the National Coalition for Adoption has funded a large education initiative that seeks to better educate adoptive families on potential emotional and behavioral problems that are connected to attachment disturbances (Wingert & Nemtsova, 2007). It is important to note that a vast majority of international adoptees adjust well to their new families.

Children being raised in the foster care system are also considered to be at risk of developing RAD (Millward et al. 2006; Minnis, Everett, Pelosi, Dunn, & Knapp, 2006). These children may have had the opportunity to bond with a primary caregiver, but have had that bond disrupted. They may have also experienced neglect or abuse from their primary caregiver. As mentioned earlier, it was estimated that there are 460,000 children in American foster care. It is believed that the number of children entering the system will continue to increase yearly (Lake, 2005).

**Review of Counseling Techniques**

 Attachment disorders are a somewhat new consideration in the field of mental health. Currently, very few, empirically tested interventions for RAD currently exist; therefore, it is befitting to examine therapies which have been found effective in treating disorders whose symptoms are significantly similar to the symptomatology of RAD (Buckner, Lopez, Dunkel, & Joiner, 2008; Hanson & Spratt, 2000). Although it would be ideal to have a flawless treatment for RAD that encompasses the etiology as well as epidemiology of the disorder, until empirically tested treatments emerge, it is prudent that counselors use therapies that have been proven effective on disorders with similar symptomatology.

Dyadic developmental therapists (Becker-Weidman, 2008) have reported success in working with families in which a member suffers from RAD. The focus of this therapeutic process is attempting to simulate the regulation process that is seen in a healthy infant–parent relationship. Typically, this would involve a child or adolescent working through a traumatic memory or experience with a focus on maintaining psychological homeostasis during the process. The parent, who is counseled in ways to remaining consistently attuned to the child’s emotional function, seeks to regulate these high states of arousal and affect. Ideally, over time, the child learns to self-regulate and builds trust in the caregiver who may have formerly represented someone who was absent or untrustworthy. This type of therapy has many common elements with any sound clinical practice, including the focus on the individual’s dignity and respect for their personal perceived experiences; however, it differs from other therapies and is particularly effective with attachment disorders in that it focuses heavily on the importance of consistently maintaining a positive effectively attuned relationship between the child and caregiver and maintaining that emotional connection with the child at a non-verbal and experiential level (Becker-Weidman, 2008).

Family therapy integrated with the use of Adler’s “early recollections” process has also shown some success when working with a child with RAD. When using early recollections to direct therapy, the premise is that specific early memories are not random, but indicative of formative events that now shape the way a person believes and therefore behaves. While this can be used to isolate specific traumatic events to be addressed with therapy, it has also been used in research studies to attempt to identify clear clinical impressions of the children diagnosed with RAD (Tobin, Wardi-Zonna, & Yezzi-Shareef, 2007).

The use of integrative play therapy is considered to be a highly beneficial form of therapy for children with RAD and has been noted as particularly successful with adoptive and foster families. More specifically, a form of therapy called Theraplay® (Theraplay Institute, 2010), is often recommended for these families. In this type of therapy, the therapist takes a very directive role in facilitating attachment through structured play. Theraplay asserts that a balance of structure, challenge, and nurturing in an environment of therapeutic playfulness will eventually lead to healthy attachment. This presupposes that healthy attachment between a child and primary caregiver will eventually eliminate significant behavioral concerns. Other techniques may integrate play therapy and key family therapies with a focus on psychoeducational approach to parenting (Weir, 2007).

Behavioral management therapy (Buckner et al., 2008) is a 10-session treatment program that emphasizes child–parent
interactions in the home as well as the therapy sessions. It has been successfully used to treat behavioral problems like defiance, aggression, and attention/concentration deficiencies in children aged 6–11. Each session has a specific goal and clients cannot progress to the next step without first sufficiently completing the one before it. The sessions include: identifying various factors which influence the child’s misbehavior and homework assignments that outline stressors (e.g., family problems inventory), the implementation of special time where the child spends 20 min/day doing an activity of their choice while the caregiver attentively comments on good/neutral behaviors, learning to give effective commands, implementing a home point system to reinforce compliance, introduction of disciplinary methods using point system and time outs, and outlining strategies such as addressing problematic behaviors in public and relapse prevention. In a case study evaluating this program, Behavioral Management Therapy (BMT) resulted in decreased problematic behaviors and increased compliance with caregiver and teacher commands. In addition to reducing problematic behaviors, the child receiving BMT increased their positive interactions with age-appropriate peers, which is especially pertinent in treating children with RAD (Buckner et al., 2008).

One of the most controversial forms of therapy that specifically exists for attachment disorder is popularly known as holding therapy but can be referred to as rebirthing, rage-reduction therapy, or attachment therapy (Buckner et al., 2008). Holding therapy (Welch, 1988) seeks to repair the broken relationship between a child and a parent by recreating the initial infant experience of establishing trust and attachment with a primary caregiver. Holding therapy maintains that the symptomatic behaviors of RAD are the result of repressed anger by children who experience pathogenic care which may seem counterintuitive considering the empirical evidence that suggests venting anger (e.g., via holding therapy) may actually increase aggression. Moreover, holding therapy may serve as a mechanism that exacerbates and reproduces the trauma these children have already experienced (Buckner et al., 2008).

While some professionals and parents claim great success with this type of therapy, there are many more that see it as detrimental. The American Academy of Child and Adolescent Psychiatry (Masters, 2005) issued a statement denying the effectiveness of such therapies and cited instances where children had died during the holding therapy process as further evidence of the danger it involved. These deaths eventually led several states to outlaw the practice of attachment therapy (Lake, 2005). Leading professionals in the field of attachment disorders have described this type of therapy as coercive, overly controlling, and have noted the danger of including age regression tactics in any type of child therapy (Wimmer, Vonk, & Reeves, 2010). Masters (2005) also states that the practice of holding therapy is not allowed in Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Center for Medicare and Medicaid Services (CMS) facilities.

A recent study (Wimmer et al., 2009) revealed that a milder form of holding in conjunction with other attachment therapy could be beneficial. In this study, the therapeutic intervention consisted of parental education about the theory of attachment and issues that arise from pathogenic care, parenting skills training to utilize outside of therapy sessions, and family therapy. An integral component to the family therapy sessions was the use of holding. The holding techniques presented in the (Wimmer et al., 2009) research do not resemble those previously described in this article and others. Instead, emotional catharsis was achieved via holding the child across the parent’s lap akin to cradling. As the child is cradled, he or she maintains eye contact with the parent while exploring issues of abuse and neglect. The authors in this study were adamant in noting that no holding techniques occurred without the explicit consent of both the parent and the child. There were some unavoidable limitations to this study’s methodology and sample; however, it does contribute to the severe shortage of empirical trials of holding therapy. It is important to note that the term attachment therapy is sometimes used in a more generic manner and can encompass a plethora of widely accepted practices.

**Implications for Mental Health Professionals**

RAD has become an increasingly popular diagnosis in recent years and is consequently worthy of the focused attention of all mental health professionals. With the increasing popularity of international adoption of older children and the ever growing need for foster care for children from broken family units, issues with disordered attachment of varying degrees will likely continue to grow in prevalence. Some research (Hanson & Spratt, 2000) has suggested that children with a history of neglect are more likely to receive this diagnosis due to the assumption that their behavioral problems and social deficiencies are the result of insufficient attachment in early childhood. Counselors must be aware that although maltreatment and pathogenic care can serve as risk factors for RAD, it is remiss to assume that the myriad of behavioral problems observed in foster care and orphaned children are mainly accounted for by this particular disorder. As health care professionals, counselors cannot be rash in assigning a diagnosis of RAD based on historical traumatic events alone. McLaughlin, Espie, and Minnis (2010) have developed a short, 10-item observational tool that could assist counselors in their diagnostic process of evaluating children for symptoms of RAD. The age range of the children used in the study was from 5 to 8 years old.

According to Wimmer, Vonk, and Bordnick (2009), many families coping with resistant and difficult children had concerns about maintaining custody of their child without significant behavioral improvement. Mental health professionals will need to work with the adoptive parents to help them understand that the process may be challenging and difficult at times, and that any positive change in their child will be difficult or impossible without their support and participation. It is also essential to remind the parents that the maladaptive behaviors their child is exhibiting did not occur overnight and that growth will take time. Additionally, the effect a child diagnosed with RAD may have on other siblings in the home may be of concern for parents. Counselors should be prepared to help parents ensure sibling safety, cope with disruption of daily routines, and implement necessary lifestyle adjustments in order to ameliorate or...
preventing a dysfunctional family environment. Mental health professionals want to discuss these issues and work with the family to develop appropriate behavior techniques, crisis intervention plans, and structure to be used in the home.

The inventory of symptoms associated with RAD often extends far beyond what is enumerated in the DSM-IV-TR based on anecdotal experience. These symptoms (e.g., incessant chatter or preoccupation with fire and blood) that are informally associated with RAD may in fact be more indicative of other disorders like conduct disorder, attention deficit/hyperactivity disorder (Hanson & Spratt, 2000), or others, which do not necessarily require a disruption in attachment. Counselors must remain cognizant that the mere existence of a history of neglect in addition to these types of symptoms does not always necessitate a diagnosis of RAD. Wimmer et al. (2009) stress the importance of developing and using effective instruments to actually measure attachment problems will be critical in future treatment of RAD.

Not all children who are subject to pathogenic care will develop RAD; however, there are risk factors that can contribute to the manifestation of this disorder. First, in accordance with parental neglect, a history of partner-violence, parental substance abuse, or adolescent parenthood can lead to disorganized parental attachment (Hanson & Spratt, 2000). Next, the age of the child at the time of maltreatment is influential in the level of developmental delays. Some research (Erickson, Egeland, & Pianta, 1989) has demonstrated that children who were mistreated as infants were more detrimentally impacted than those who were maltreated later in childhood. Finally, posttraumatic stress disorder, anxiety disorders, or adjustment disorders may be more appropriate diagnoses because these disorders encompass many of the symptoms of RAD without requiring that the child have an inability to form attachments. A child’s maladaptive behaviors can many times be conceptualized as learned responses to a nonaffirming environment rather than a clinical diagnosis. This differentiation can have a significant effect on what treatment plan is utilized (Hanson & Spratt, 2000).

Counseling professionals working in a school setting would benefit to learn about this disorder, as they could potentially be the first professionals to encounter a child after the traumatic experience of disrupted attachment through foster care placement or parental neglect. These groups of students are already at risk of maladjustment and increased concern for their well-being may expose RAD symptoms or at the very least identify students who need extra assistance adjusting to their new lives. As mentioned earlier, school counselors could also use the short observational tool developed by McLaughlin et al. (2010) to help recognize the symptoms of RAD in young children.

**Conclusion**

It is well documented that postadoption services have increased dramatically since the 1990s, yet the end results for these children remain unknown (Wimmer et al., 2009). As foster care placements and adoption rates increase, it is imperative that mental health professionals be competent in diagnosing and treating RAD. Counselors must be vigilant in their diagnosis techniques and protocol to prevent overdiagnosis and utilize empirically tested treatment techniques that have been proven effective in treating disorders with similar symptomatology. In addition to the need for more elaborate research on this disorder and its etiology as well as epidemiology, there is a glaring need for further enforceable preventative measures. In many cases, attachment disorders stem from a preventable trauma. The need for readily available parenting classes, education, early intervention funding, more extensive foster care training on attachment, and a stronger focus on family reunification when possible is an overwhelming missing link in the available research that has yet to be addressed. To accomplish this, professionals working with adoptive or foster care populations need to be educated on attachment theory and the potentially harmful effects of abuse and neglect. Moreover, to increase proficiency in serving this population, mental health professionals should be well versed in current RAD research and engage in research that furthers evidence of efficacious treatment options. Research should continue to explore the causes, implications, and treatments for this disorder that continues to plague children and families.

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