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**REACTIVE ATTACHMENT DISORDER:
CHALLENGES FOR EARLY IDENTIFICATION AND INTERVENTION WITHIN THE
SCHOOLS**

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Attachment is of key importance in childhood development. The quality of attachment relationship between the child and parent/primary caregiver may have an effect on the child and future relationships and social success (Rubin, Bukowski, & Parker, 1998). When a child fails to bond with a caring adult, attachment becomes disordered and children may not be able to bond appropriately or at all with other people. This inability to relate and connect with others may disrupt or arrest not only children's social development, but also their overall development. The purpose of this review is to synthesize information and research on characteristics, diagnosis, and interventions currently in practice in working with young children with Reactive Attachment Disorder (RAD). A discussion will highlight the themes found during this review and conclude with implications for intervention and practice.

Introduction and Statement of the Problem

Social development for children is important and it begins in the early years of their lives (Hartup, 1992; Katz & McClellan, 1997; Ladd & Coleman, 1993). From infancy, children interact with the physical and social world around them and begin to build relationships through active engagement and interdependence with others (Ladd & Coleman, 1993). One of the first developmental steps for young children begins through forming relationships with familiar adults during infancy (Howes, 1987).

This connection is referred to as attachment, and the quality of attachment relationships may have an effect on future social success and relationships (Rubin, Bukowski, & Parker, 1998). Specifically, it has been suggested that children who have a secure attachment relationship with a caring adult are more disposed to interact with other children and have greater expectations that their interactions will be positive (Howes, 1987; Rubin et al., 1998). When children fail to bond with a caring adult, attachment becomes disordered and may impede appropriate bonding in future relationships. A failure to bond may be generated by a variety of early experiences (e.g., abandonment, neglect, abuse) characterized by pathogenic care. One of the diagnostic options for children with bonding and attachment difficulties manifesting in behaviors is the diagnosis of Reactive Attachment Disorder (RAD). Recognized by an increasing numbers of students identified with RAD, school systems are beginning to realize the substantial needs these children must have addressed within the school setting (Davis, Kruczek, & McIntosh (2006).

One of the challenges with the identification of RAD lies in effective assessment instruments or protocols to diagnose RAD and distinguish RAD from other identifications. Once identified, there are few organized and empirically proven intervention methods to help ameliorate its negative effects on the development of children. The purpose of this review is to explore the implications between pathological care and a resulting impairment in attachment. This review will begin with a brief examination of basic attachment theory and the resulting implications should maltreatment occur. The authors will make the case that RAD is an issue that schools must deal with to help children reach their developmental potential. We will conclude with a discussion of the current implication for future assessment components and potential intervention strategies.

Background and Significance

A leading child developmental issue is the concept of attachment. It is beyond the scope of this review to examine in length the typical course of attachment, but it is important to demonstrate a summary of classic attachment milestones. Children typically move from social responsiveness in which children react to smiling and facial expressions of caregivers, to differentiating responses from known to unknown caregivers. Between eight months and three years, children will demonstrate fondness for particular caregivers that provide support, guidance, and a secure foundation from which to explore the world around them. Beyond the age of three, the attachment of children to others is largely language and communication based, becoming increasingly entangled with cooperative activities, separation, and proximally based security. Bowlby (1980) theorized it is during these early developmental stages that children are able to view themselves as worthy of attention, praise, love, and thus provides substantial footing for future, positive relationships.

Dissimilarly, children who experience maltreatment or removal of a significant caregiver during the formative early years are at risk for developing significant deficits in social relatedness, competence, and development. Bowlby (1980) and Ainsworth (1978) were two of the early researchers that examined causation between social deprivation and later pathology. The work of these researchers, even though distinctively different in focus, supported the correlation between early child maltreatment and an increased risk for psychosocial difficulties. Bowlby conceded that a person's interpersonal skills and relationships could be associated, even predicted, by viewing early relationships designs (Hardy, 2007). Additionally, *data from divergent sources support the notion that a history of neglect and/or abuse compromises the ability to form stable attachments with a primary caregiver, and thus might result in Reactive Attachment Disorder (RAD)* (Hanson & Spratt, 2000). The DSM-IV-TR (2000) conceptualizes RAD as a condition resulting from pathogenic care and characterized by an inability to engage in social relationships or form emotional attachment to others. Children with this condition may exhibit problematic behaviors due to deficits in social and emotional development as well as in other developmental areas (i.e., language, behavior, and communication). Table 1 provides a more detailed description of the diagnostic criterion for RAD.

Table 1
DSM-IV-TR Diagnostic Criteria for Reactive Attachment Disorder of Infancy or Early Childhood

Types	
<p>A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years as evidenced by:</p>	<p>Inhibited: Persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hyper vigilant, or highly ambivalent and contradictory responses</p> <p>Disinhibited: Diffuse attachments as manifest by indiscriminant sociability with marked inability to exhibit appropriate selective attachments</p>
<p>B. The disturbance in Criterion A is not accounted for solely by developmental delay and does not meet criteria for a pervasive developmental disorder.</p>	
<p>C. Pathogenic care as evidenced by at least one of the following:</p> <ol style="list-style-type: none"> 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; and 3. repeated changes in primary caregiver that prevent formation of stable attachments 	
<p>D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A.</p>	

Diagnostic criteria and the prevalence of RAD continue to be areas of debate among researchers (Sheperis, Doggett, Hoda, Blanchard, Renfro-Michel, Holdiness, & Schlagheck, 2003). One such challenge in diagnosing RAD is the commonality of symptoms between RAD and other conduct and behavior disorders (Sheperis, et al., 2003). The distinguishing aspect of the clinical diagnosis of RAD is that it is a result of ongoing, pathogenic care (DSM-IV-TR, 2000).

As illustrated in the previous discussion, attachment is a critical issue in childhood development. When working with children in foster and adoptive homes the importance of attachment and attachment disorders is exacerbated. Cicchetti and Toth (1995) conceded that there is a greater likelihood of negative and incomplete social and cognitive development outcomes in maltreated

children. Furthermore, the maladaptive behaviors extend to dysregulation, poor social skills development, and ultimately poor adaptation to the school environment (Cicchetti & Lynch, 1995).

Beyond just the medical and clinical walls, RAD affects school systems and childcare settings at alarming rates. Davis, Kruczek, & McIntosh (2006), cited that the prevalence rates and diagnosis has been on the rise in terms of special education services and identification, but little empirical research and literature have provided treatment of psychopathological disorders, such as RAD, within the school environment. RAD not only may be exacerbated by the academic and school arena, but the mere design and expectations of self-regulation within school itself, align children with RAD off the mark from the very onset (Schwartz & Davis, 2006). Therefore, it would behoove schools to have a stake in the development of an appropriate protocol for both identification and intervention systems, as much work is needed to ameliorate the trauma from early maltreatment.

Method

The purpose of this review is three-fold: (a) conduct a literature review of scholarly publications in the area of Reactive Attachment Disorder (RAD) that focus on the area early childhood, (b) identify effective measures associated with RAD, (c) and describe implications for intervention considerations.

Procedures

An examination of the literature was accomplished by applying four procedures. These included (a) search, (b) inclusion criteria, (c) relevance, and (d) article analysis form (see Appendix A). The following section provides detail regarding each procedure.

Search Procedures

The article search procedures were conducted by using the following components: (a) electronic-based searches in the Library Information Access System through the Educational Resources Information Center (ERIC), ProQuest, PsychInfo, and Infotrac using reactive attachment disorder with each of the following key descriptors or truncation: early childhood, measure, assessment, and preschool; (b) a hand-based search of refereed journals publishing articles on RAD, early childhood, and measure; and (c) a traditional search using the reference section of articles obtained through the above two methods.

Inclusion Criteria

Using the selection criteria procedures described above, a total of 50 articles were found. The selection criterion was further refined by limiting the inclusion to reactive attachment disorder with the following categories: early childhood (n=11), then further refinement of measures (n=7). Articles published between 1994 and 2007 were reviewed to establish the relevance to the special topic of the reactive attachment disorder and the identification measures used with children birth through five years. Only peer-reviewed articles are present within the review.

An article was determined relevant and included if it was published between 1994 and 2007 and the primary focus of the article was related to RAD in the areas of preschool, early childhood, and measures. Articles were excluded if measures were only mentioned as a consideration or a recommendation, or if assessment or treatment was conducted on children older than five. As formerly mentioned only articles from peer reviewed journals were included in this review.

Article Analysis

A content analysis form (Appendix A) was generated to provide a summary of each article. The analysis form was divided into six categories: (a) Background information; (b) Participant Characteristics; (c) Research Design; (d) Practice characteristics; (e) Outcomes; and (f) Synthesis Findings.

Limitations

This review was a focused examination of current articles (within the last thirteen years) specifically addressing reactive attachment disorder, measures, and early childhood. Because of the specific nature of this review, limitations are noted. One possible limitation may be the omission of important articles written prior to 1994, or work not published in peer reviewed journals (e.g., reports, conference papers, etc.). Another possible limitation may be the exclusion of articles outside the parameters of all three descriptors (i.e., reactive attachment disorder, measures, and early childhood). Only journal articles published in English were included in this review.

Analysis of Research

Since this first inclusion in DSM manuals, an increasing number of research studies examined the

relationship between poor attachment and pathological care and the identification of children diagnosed with RAD (Mukaddes, Bilge, Alyanak, & Kora, 2000). This review will investigate the following themes present in the current body of research: Comorbidity; Differential Diagnosis; Lack of Consistent Assessment Protocol.

Comorbidity

As previously mentioned, one of the concerns of identifying of RAD, is the notion of identification challenges due to comorbidity factors. Cicchetti & Toth (1995) compared groups of nonmaltreated children with children who had experienced maltreatment from comparable socioeconomic backgrounds. These researchers found that the children who had experienced maltreatment manifested significantly greater maladaptive functioning across developmental domains. This finding suggests the presence of child maltreatment affects children over and above the effects of poverty. In keeping with this line of research, Hanson and Spratt (2000) suggested using caution before over identifying a group of children, as this might create a superfluous or partial diagnosis.

Additionally, the work by Richters and Volkmar (1994) deem it imperative to include the pathological familial background. Rosenstein and Horowitz (1996) opened the debate further to identify many factors affecting the diagnosis including traumatic familiar history and economic conditions. Not only does poverty and socioeconomic status level appear to be comorbidity factors, but other disorders can be comorbidity factors as well. For example, Hughes (1997) reported that children with RAD are typically intense and pervasive and struggle to find joy, mutuality, and reciprocity in their interactions with others, which parallels many therapist views of a child suffering from depression. Hanson & Spratt (2000) also noted that there is a potential overlap with post-traumatic stress disorder and substance use.

Another example of disorders being comorbidity factors is the ongoing practice of dually diagnosing children with Autism and RAD. Richters & Volkmar (1994) point out similarities between children with autism spectrum disorder, but also conclude that children with RAD typically do appear to be more socially related than do children with autism. Mukaddes, Alyanak, & Kora (2000) suggested distinguishing the two identifications can be based on the following: children with RAD do have a normal social capacity; they can recover and respond in socially appropriate ways; lack most autistic symptoms even when language deficits were existent; no restrictive areas of interest were noted when working with children with RAD; and, unlike many children with autism, there were no severe cognitive deficits which were resistant to change.

Differential Diagnosis

The recent increases in the identification and diagnosis of RAD have been debated (Sheperis et al., 2003). Many researchers believe that RAD mirrors many other DSM-IV-TR (2000) diagnostic categories, making a true identification difficult and questionable (Sheperis, Renfro-Michel, & Doggett, 2003). Table 2 presents several commonly shared diagnosis and crossover characteristics. Hanson and Spratt (2000) explored another quandary in diagnosing children with RAD; the researchers point out the fact that the terms bonding and attachment in and of themselves create diagnostic confusion, with many researchers seemingly not noting a difference between the two terms. By not defining clearly the terms assigned to the definitional aspect, present conceptualization difficulties when interpreting increases or decreases in identification of children with RAD will continue to exist.

Hall & Geher (2003) state further that the diagnosis of RAD may or may not include such psychosomatic complaints that may be confused with diagnosed depression. Additionally, the researchers recognized that it is perhaps futile for a definitive diagnosis of RAD given that so much information and knowledge regarding the disorder is not complete. Hanson & Spratt (2000) echod the challenges of differential diagnosis given that without identified disruptions in attachment, children could easily be diagnosed with a Conduct Disorder or Attention Deficit/Hyperactivity Disorder.

Table 2
Diagnostic Differences in Childhood Disorders

DISORDER	KEY COMPONENTS OF DIAGNOSIS	DIFFERENTIAL DIAGNOSIS FACTORS
Reactive Attachment Disorder of Infancy or Early Childhood 313.89	Overall symptomatology resulting from pathogenic care	Symptomatology similar to other disorders listed, but occur due to ongoing pathogenic care (see <i>DSM-IV-TR</i> for definition)
	Inhibited Type – Persistent inability to engage in or respond in appropriate social relationships	Social and attachment issues present
Conduct Disorder 312.81	Disinhibited Type – Little to no discrimination given in selecting attachment figures	May exhibit language, behavior, and communication deficits, but typically are a result of poor care versus a developmental origin
	Persistent pattern of severe behavior that violates the basic rights of others	May have been in restrictive emotional environment Anti-social and aggressive behaviors lead to decreased ability to develop adequate social relationships
Oppositional Defiant Disorder 313.81	Pattern of defiant behavior toward authority figures	Behaviors overall are not intended to harm others
Attention-Deficit Hyperactivity Disorder 314.01	Behaviors centered around deflecting self blame	Social difficulties occur due to defiant behaviors
	Pattern of impulsivity and hyperactivity causing disturbances in school and home functioning	Disinhibited social behavior resulting from impulsivity versus seeking comfort from attachment figure
Autistic Disorder 299.00	Social deficits that may occur stem from these impulsive behaviors	Behaviors are not being done to intentionally bother another individual
	Restricted level of interests and activities	Social impairments stem from restricted field of interest and communication deficits present
	Normally accompanied by marked disturbance in communication and repetitive stereotypic behaviors	

Note: All information taken directly from *DSM-IV-TR* (American Psychiatric Association, 2000)

Lack of Consistent Assessment Protocol

Further complicating the challenges comorbidity and differential diagnosis create when identifying RAD, there is currently no universally accepted assessment tool for identifying children with RAD (Hanson & Spratt, 2000). The lack of such a tool creates a situation where many children may be misdiagnosed. In addition, not having a well-developed assessment protocol may potentially limit the possibility of generating and researching effective intervention strategies used in clinical and school settings. Crittenden, Claussen, and Kozlowska (2007) cited that *there is uncertainty about how to assess attachment and the implications of different assessment measures*. Furthermore, *if attachment is to become meaningful in clinical application, formal and replicable assessments are essential* (pg. 78).

Although basic attachment theory is the guidepost for most researchers in examining RAD, various researchers and professionals may adhere to different assessment measures. Table 3 outlines assessments typically used when diagnosing preschool children with RAD. In an effort to standardize an assessment protocol for diagnosing RAD, Sheperis, Doggett, Hoda, Blanchard, Renfro-Michel, Holdiness, & Schlagheck (2003) evaluated the use and elements of assessments currently in practice for diagnosing children with RAD and subsequently proposed an assessment protocol for a more effective measure. These researchers commented on the difficulties of creating a universal protocol, highlighting how complicated it was to tease out the key factors for an accurate identification. Ultimately, they concluded that any assessment protocol should include the following key components: (a) distinguishing cognitive and lingual characteristics of RAD from other developmental disorders; (b)

noting behavioral portions even though they overlap with other conduct disorders; (c) specifically addressing the origin of the disorders; and, (d) placing emphasis on all of this areas listed when making the diagnosis (Sheperis et al., 2003).

Table 3
Psychometric Instruments Reference

Instrument	Age Norms	Outcome Measures	Application to RAD
Child Behavioral Checklist (CBCL)	2-18 years	Access behavior problems; access ability	Distinguished between externalizing and internalizing behaviors
Parent and Teacher Report Form of CBCL	2-18 years	Home and school behavior reference	Identification of behaviors across settings
Eyeberg Child Inventory (ECBI)	2-16 years	Assists in examining the severity of conduct disorder	Examines inappropriate behaviors and behavioral characteristics
Sutter-Eyberg Student Behavior Inventory Revised (SESBI-R)	2-17 years	Assists in examining the severity of conduct disorder in school environment	Assists in quantifying RAD symptoms; assists in differential diagnosis of RAD
Randolph Attachment Disorder Questionnaire (RADQ)	5-18 years	Distinguishes between behavior and attachment disorders	Aids in differential diagnosis for the clinician
Parent Infant Global Assessment	0-3	Ranges from well-adapted to grossly impaired	Assists in identifying the source of the attachment problems – Caregiver v. larger social environment
Developmental Observation Checklist System-Revised	0-6 years	Addresses concerns regarding general development, adjustment behavior, and parent stress and support	Aids in differentiating levels and predictors
Strange Situation	Early infancy	Defines attachment patterns	Not used for clinical diagnosis, but assist in formulating attachment positives and negatives

Implications

In an effort to enhance the skills of young children with RAD and to better prepare them for success in school and life, some of the challenges facing today's schools were examined. Additionally, suggestions from the literature to improve school readiness intervention were considered.

Challenges for School Readiness and Performance

Children with RAD present a unique challenges entering school. Blair pointed out that social and emotional school readiness is critical to a smooth transition to kindergarten and early school success (2000). Children entering school diagnosed with RAD may present to schools with a myriad of behavioral, cognitive, and academic challenges and deficits. An aspect that many researchers agree upon is that children with RAD consistently exhibit more teacher-attention seeking behaviors, over dependence upon a teacher, significantly more emotional dependency, and are more likely to engage in proximity-seeking behaviors (Kobak et al., 2003, Blair, 2002, & Cicchetti, 2004).

There is limited research to review of programs serving children with RAD within the school setting, but much of what is available presents very similarly to that of other maltreated children (Perry, 2001). Like programs and interventions for maltreated children, programs and interventions for children with RAD would include, but would not be limited to: a) nurturing the child; b) understanding behaviors before punishing; c) interacting with children based on emotional age; d) being consistent, predictable, and repetitive; e) modeling and teach appropriate play and social behaviors; f) maintaining realistic expectations; g) being patient with child and self; and using resources (Perry, 2001).

Self-Regulation

Self-regulation presents significantly challenged options for children entering school (Schwartz & Davis, 2006). Therefore, a key for school personnel is to assist in improving a child's ability to regulate his or her own feelings. Children with RAD would need more specific and targeted interventions to improve their self-regulation because of persistent and serious interpersonal deficits. Hanson and Sprat (2000) suggest cognitive behavioral management of mood symptoms, behavior modification, and psycho education as possible intervention strategies.

Social Competence

Children with RAD tend to be more aggressive, anti-social, and harm other children at school that is a manifestation of the child's poor social competence. In a forethought of possible intervention strategies, Kennedy and Kennedy suggested that the teacher-student relationship, and by extension other relationships both in school and outside school, are inextricably tied to a child's internal working model of a parent-child relationship, and that the teacher-child relationship may be the most influential factor and strongest predictor of school success (2004). Therefore, rigorous and focused efforts need to be concentrated on enhancing social competence. The outcome measures should correspond with the basic goals of attachment – proximity, security, safety, and self-regulation, as well as helping reframe the child's behavior, keeping in mind the child's basic need of compensation for unmet needs of attachment (Kobak et al, 2000). Without well-developed interventions in the school setting, children with RAD may have increasingly serious problems relating to others including teachers and peers (Ritchie, 1996).

*Implications for Future Research**Development of Assessment Protocol*

Children with RAD are, at best, a challenge in properly identifying regardless of the child's age. Therefore, continued research needs to address the reliability and validity of assessment measures and protocols to assist in accurately identifying children with RAD. Kratochwill considers observation as the hallmark for behavioral assessment, even more critical for children under the age of eight (1999). Observations need to occur in a variety of situations and conditions. Sheperis et al., (2003) outlined a conditioned observation system that highlight the variety of anxiety and conditions that heightened typical RAD behavioral characteristics (2003).

Intervention Considerations

In a study by Wilson, it was determined that there are significant barriers to traditional therapies when working with children with RAD which include the inability to profit from experiences, minimal desire to change, little or no regard for authority, and poor impulse control (2001). Schwartz & Davis (2006) documented that few validated therapeutic interventions are published in peer-reviewed journals distinguished for children with RAD. Therefore, much of the interventions for children with RAD mimic therapies for children identified as abused and/or neglected as stated before. When the child with RAD is within the school setting, it is imperative for the school psychologist to take an active role in educating the teachers and staff of the critical role they each will play in the child's success or failure at school.

It is important for teachers to know the dire need children with RAD possess for needing stability and sense of security (Schwartz & Davis, 2006). Mattison & Forness (1995) point out the importance of school psychologist in providing support, guidance, and establishment of behavioral manifestations of children with RAD to the child's educators. Kobak et al., (2001) additionally outlined the key role psychologist and counselors play in the adaptive ability of children with the school environment. When the teachers understood more about RAD, they were more likely to demonstrate a willingness to support the child as well as assisting in helping to reframe the child's unmet attachment needs. In addition, Kobak et al.,(2001) found that psychologists, counselors, and teachers are all key factors in helping the child with RAD develop a secure base and effectively regulate emotions through interactive teaching, counseling, and modeling of appropriate social behaviors.

When developing therapy goals for children diagnosed with RAD, careful plans should be generated around the child's need for developing self-control, developing a self-identity, understanding natural consequences, and reinforcing reciprocity and nurturing. Zeanah (1999) identified that key factors for children with RAD to be successful within the confines of the school setting, the interventions must be child specific, developmentally appropriate, and reduction in negative practices and emotional pressuring. Haugaard & Hazan (2004) further recommend that any intervention should also address self-esteem and self-efficacy to improve overall functioning.

Summary

Schwartz & Davis (2006) discussed that schools can become triggers of increased anxiety and possible rejection for students with RAD given the conflicting requests brought about by the natural consequences of delayed gratification, coupled with their inability to regulate emotions. Therefore, a key element to any intervention for children with RAD in the school environment must address self-

regulation. It is imperative that children with RAD learn to regulate their feelings and actions. This learning will only occur with deliberate and consistent instruction. Creating a reliable, predictable, and secure learning environment are essential considerations when developing interventions for children with RAD. Given the history of maltreatment and distrust children with RAD have with adults, it is imperative that those entrusted with developing the intervention plans are well versed in attachment theory and development in order to create a plan of benefit and not detriment to the child.

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