Is it reactive attachment disorder or not?

PRESENTED BY:
FORREST LIEN, EXECUTIVE DIRECTOR
INSTITUTE FOR ATTACHMENT & CHILD DEVELOPMENT

instituteforattachment.org
Your hosts

FORREST LIEN
INSTITUTE FOR ATTACHMENT & CHILD DEVELOPMENT (IACD) EXECUTIVE DIRECTOR

JULIE BEEM
ATTACHMENT & TRAUMA NETWORK (ATN) EXECUTIVE DIRECTOR
Agenda today

- Defining attachment disorder
- The connection between mental illness and attachment disorder
- How children’s current living environments affects their symptoms
Defining attachment disorder
DSM-5 definitions of RAD & DSED

**Reactive Attachment Disorder (RAD)**

A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers

A persistent social and emotional disturbance

A pattern of extremes of insufficient care

The care described in the third criterion is presumed to be responsible for the disturbed behavior described in the first criterion

The criteria for autism spectrum disorder are not met

The disturbance is evident before age 5 years

The child has a developmental age of at least 9 months

**Disinhibited Social Engagement Disorder (DSED)**

A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults in an impulsive, incautious, and over familiar way

The behaviors described in the first criterion are not limited to impulsivity but also include socially disinhibited behavior

A pattern of extremes of insufficient care

The care described in the third criterion is presumed to be responsible for the disturbed behavior described in the first criterion

The child has a developmental age of at least 9 months
Developmental trauma disorder - a better name/definition

- A diagnostic proposal for DSM-5, authored by Bessel van der Kolk and colleagues
- Based on a wide array of research data that comprises tens of thousands of children across multiple research studies
- 80% of all child maltreatment is at the hands of children’s own parents. Maltreatment embeds “hidden traumas” in infant - caregiver interactions that are neglectful, intrusive, unpredictable, threatening, aggressive, rejecting, or exploitive
- Definition based on the experiences of young children raised in an interpersonal context of ongoing danger, maltreatment, unpredictability and/or neglect. These interactions convey that the world is a dangerous, unreliable, and/or indifferent place that offers little or no safety. Given the highly limited capacities of infants / young children to assess risk, this lack of physical and/or emotional safety quickly rises to the level of a subjective survival threat (annihilation anxiety) even though the objective nature of the event may not actually be at that level. For this reason, such events do not warrant a diagnosis of PTSD because the events are not “imminently life threatening”, a criteria for PTSD. However, it is subjective perception, and not objective lethality, that determines trauma. Using PTSD criteria, the element of trauma gets missed, and the erroneous diagnostic process has begun.
Symptoms of developmental trauma disorder

**Affective and physiological dysregulation:**
Unable to self-regulate from strong emotional states
Rages
Disturbances in regulation of bodily functions (sleeping, eating, and elimination)
Sensory over or under-reactivity
Lack of awareness of or dissociation from sensations, emotions, and bodily states
Lack of ability to describe emotions or bodily states

**Attentional and behavioral dysregulation:**
Hypervigilant
Self-harming, risk-taking, and/or thrill-seeking behaviors
Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation)
Habitual (intentional or automatic) or reactive self-harm
Inability to initiate or sustain goal-directed behavior

**Self and relational dysregulation:**
Parentified behavior
Extreme concern over the safety and well-being of the primary caregiver
Persistent negative sense of self
Distrust of others
Reactive physical or verbal aggression
Inappropriate intimacy (physical or emotional)
Lack of empathy
What is attachment disorder?

- An attachment disorder is a condition in which individuals have difficulty forming loving, lasting, intimate relationships.
- The words attachment and bonding are generally used interchangeably.
- Attachment disorders vary in severity, but the term is usually reserved for individuals who show a nearly complete lack of ability to be genuinely affectionate or empathic with others. They typically fail to develop a conscience and do not learn to trust.
Attachment cycle at age 1-(Erik Erikson’s stages of development)

Necessary ingredients for development of basic trust and attachment:

- Eye Contact
- Food
- Motion
- Touch
- Verbal Contact
- Emotional Contact
- Smiles
Attachment cycle at age 2

Necessary ingredients of development of autonomy, good character foundation and conscience:

The freedom to explore and make good choices for oneself within the limits of parental oversight and control.
Symptoms of reactive disorder (symptoms for ages 6-18, measured from rarely to usually) attachment

- Superficially engaging, charming (phoniness)
- Trouble making eye contact
- Indiscriminately affectionate with strangers
- Lacking ability to give and receive affection (not cuddly on parents terms)
- Argues for long periods often over ridiculous things
- Extreme control problems: often manifest in covert or “sneaky” ways
- Acts amazingly innocent when caught doing something wrong
- Destructive to self, others, things
- Self-soothing behaviors self-soothing (e.g., rocking and other rhythmical movements
- Controlling with animals and younger children

- Temper tantrums over the smallest correction or told NO to requests
- Chronic lying and stealing
- Poor impulse controls (joy in the moment)
- Learning lags and disorders (learned helplessness)
- Poor cause and effect thinking
- Lack of conscience
- Abnormal eating patterns
- Can’t keep friends for more than a week
- Preoccupied nonsense questions and incessant chatter
- Parents appear unreasonably hostile and angry
MANUAL for the
RANDOLPH
ATTACHMENT
DISORDER
QUESTIONNAIRE

Third Edition
by Elizabeth M. Randolph, MSN, PhD
Sub-types of attachment disorder

Avoidant-isolation, avoid closeness, seldom seek comfort, avoid relationships, passive-aggressive, avoid feelings, intense sadness and loneliness, believe their rejection by birth mom was justified

Anxious-constant blatant lying, fake emotions, emotionally empty, “good actors”, chameleons, often fool therapists that they’re normal and parents aren’t

Disorganized-disorganized, odd, and bizarre behaviors. Other psychiatric disorders, unpredictable moods, excessively excitable, frequent sensory or neurological problems, difficult to manage

Ambivalent-openly angry, defiant, destructive, dangerous, superficially charming, lack of empathy, delinquent acts, most prevalent subtype in mental health systems
Brain organization/development - Simple to complex:

**Brain responsible for survival/biological responses, i.e.:**
- Heart rate
- Blood pressure
- Arousal states

**Limbic/midbrain responsible for:**
- Emotion
- Attachment
- Affect regulation

**Cortex is responsible for:**
- Abstract reasoning
- Complex language

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**Brainstem**
(arrives hard-wired and on-line)

**Limbic/Midbrain**
(carries blue-print only)

**Cortex**
(arrives blue-print only)
Abuse/PTSD

Traumatic Event
(physical and sexual abuse and domestic violence)

prolonged alarm reaction

Release of stress-based hormones (catecholamine)

Normal stress Response is reversible

Two distinct neuronal response patterns “adaptive style”

Arousal continuum

Dissociative continuum

ALTERED BRAIN DEVELOPMENT

“STATES BECOME TRAITS”
Sensitized to external cues
The look of PTSD
Connection between mental illness and attachment disorder
RAD & mental illness connection

ANTISOCIAL (SOCIOPATHIC) PERSONALITY DISORDER - Many of the diagnostic characteristics of children with RAD also fit adult characteristics of antisocial personality disorder including cruelty to people or animals, lying, stealing, fire setting, failure to conform to social norms, irritability, aggressively and impulsivity. They have little regard for the truth and lack empathy and remorse. Many of these adults were themselves abused or neglected in early childhood.

BORDERLINE PERSONALITY DISORDER - The etiology of Borderline Personality Disorder is not well understood, but there is evidence of both genetic and psychological influences, to some degree attributable to poor parenting (neglect or over-protective) between birth and three years of age. Borderline Personality Disorder manifests as long-term patterns of unstable mood, interpersonal relationships and self image.

ALCOHOL/SUBSTANCE ABUSE - In my experience working with abused kids, this is the single most common characteristic of abusing parents. However, in my experience, it is also most commonly a coexistent factor of abuse. In other words, while alcohol and substance abusing parents may abuse their children, it is usually of less severity and is usually not in an ongoing manner. Purely alcohol or substance abusing parents who over-indulge and neglect or abuse their children are ordinarily regretful and remorseful of their actions.

BIPOLAR DISORDER - This is a common psychiatric mood disorder representing 2 to 3 percent of the general population. It is a genetic, inherited, familial disorder that ultimately results in biochemical imbalances within one’s central nervous system. It manifests in manic (or hypomanic, a lesser form of manic) and/or depressive mood disturbances. In my professional experience, this is by far the disorder that has the greatest coincidence with abuse or neglect of children and as such is the genetic disorder that these children with coexistent Reactive Attachment Disorder also inherit. The degree of self-centeredness, irritability and intensity of rage reactions while in a manic state is frequently sufficient to create severe abusive conditions. Correspondingly, the degree of profound depression is likewise severe and prolonged enough to create long standing neglectful circumstances.
Characteristics of attention deficit disorder, bipolar disorder, and reactive attachment disorder

Courtesy of John F. Alston, M.D., P.C.
Evergreen, Colorado (303)-670-0926 (see full chart at www.johnalstonmd.com)

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Attention Deficit Disorder</th>
<th>Bipolar Disorder</th>
<th>Reactive Attachment Disorder</th>
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<tbody>
<tr>
<td>Age of Onset</td>
<td>Infancy to toddler, 6 years, 13 years</td>
<td>2 to 3 years, 6 years, 13 to 25 years</td>
<td>Birth to 3 years</td>
</tr>
<tr>
<td>Family History</td>
<td>ADHD, academic difficulties (based on task incompletion), alcohol and substance abuse</td>
<td>Any mood disorder (depression or bipolar), academic difficulties (based on motivation problems or opposition or defiance), alcohol and substance abuse, adoption, ADHD</td>
<td>Abuse and neglect, severe emotional and behavior disorders, alcohol, and substance abuse. Abuse neglect in parents’ own early life</td>
</tr>
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<td>Lifelong Prevalence</td>
<td>3 to 6 % general population</td>
<td>3 to 5 % of general population</td>
<td>Uncommon to common</td>
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<tr>
<td>Etiology</td>
<td>Genetic, Neurochemical, fetal development, brain traumas, nutritional deficiencies, exacerbated by stress</td>
<td>Genetic, exacerbated by stress and hormones</td>
<td>Psycho physiologic secondary to neglect, abuse, mistreatment, abandonment</td>
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### Psychopharmacology

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<td>Medications helpful include Adderall, Methylphenidate, Dexedrine, Bupropion. Clonidine and Guanfacine may be useful as additive medications.</td>
<td>Medications helpful to stabilize mood include Valproate, Lithium, Carbamazepine and Gabapentin. Medications helpful for opposition and rage include Olanzapine, Quetiapine, Risperidone and Ziprasidone. Bupropion helpful for mood and motivational enhancement.</td>
<td>Antidepressants, Clonidine, Guanfacine may help decrease hyper vigilance. Medications do not help characterological traits.</td>
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### Prognosis

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<td>Good to excellent with appropriate medical treatment, ancillary therapies and educational accommodations.</td>
<td>Fair to good with times of regression even with appropriate and effective medical treatment.</td>
<td>Highly variable, dependent upon recognition of comorbid mood disorders, degree of abuse/neglect, age of relinquishment, innate temperament and effects of treatment.</td>
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How children’s current living environments affect their symptoms
Rejection of the nurturing enemy
Post-traumatic stress in parents

**Causes**

- Repeated rejections by child - giving and giving with little or no lasting positive return
- Relentless, unending control battles - need for incredible self-control at all times
- Changes within yourself & family that seem out of your control & are not apparent choices

**Primary Symptoms**

- Avoidance of thoughts & feeling, decreased interest & participation in significant events
- Psychological/Physical distress at exposure to trigger events that symbolize the trauma
- Decreased affect & display of feelings, sense of being detached or estranged from others

**Secondary Symptoms & Effects**

- Feeling that you are unlike Others, damaged sense of self-worth, feeling out of control of emotion
- Selectivity in perceptions, victim identity, fatigue and depression, loss of security
- Increase arousal sleep problems, Irritable, angry, hyper vigilance, higher startle response
- Helplessness Hopelessness Anger RAGE

Institute For Attachment & Child Development
Saving Children. Saving Families. Saving Lives
Working with parents of children with RAD
Assessing the developmental level and needs of parents (through autobiographies and MCMI Screening)

- Intact at-risk family – child remains in abusive situation
- High incidence of parents with poor attachment histories of their own
  - All of the qualities of unattached children still present in adults
  - Not available for education (cortex)

- Foster families
  - Assess availability for work of attachment
  - Impact of personal trauma history – usually not explored

- Adoptive families
  - Education re: attachment and trauma
  - Family of origin history will become important and needs to be explored over time
  - RESPITE!
Thank you for joining us today and to ATN for helping to make this webinar possible!

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