An Uncommon Disorder That Is Fairly Common among Institutionalized Children

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Reactive attachment disorder (RAD) is a psychological disorder that affects a child's ability to develop appropriate social relatedness. It was first added to the Diagnostic and Statistical Manual in 1980s. There are two types of RAD: inhibited, which results in extreme social isolation and watchfulness, and disinhibited, which results in inappropriate social familiarity and lack of discriminate attachment. The disproportionate prevalence of RAD in children in the foster care or orphanage system speaks to the importance of addressing this disorder. It is believed that the prevalence of RAD can be reduced through reforms to these institutions, internationally.

The Current American Foster Care System

The American foster care system is not in an ideal state (Mandell, 2006). Youth are aging out of the foster care system ill equipped to establish an independent and thriving life, while adults who were once a part of the system are found to have double the rate of mental illness and are three times more likely to live in poverty (Allen & Vacca, 2010; Mandell, 2006; Vacca, 2008). One possible contributing factor to these dismal statistics is reactive attachment disorder (RAD), a psychological malady that affects one's ability to form connections with others. RAD is believed to be an outcome of placement instability, as children in foster care are continuously transferred in and out of homes and are therefore less likely to form stable relationships with primary caregivers (Stott & Gustavsson, 2010). When children display actions that are symptomatic of RAD, the behaviors are often dismissed as trivial delinquent actions, and RAD is therefore left undiagnosed (Zeanah et al., 2004). Unfortunately, a significant proportion of these children live life with an inability to form attachments with others (Hornor, 2008), which is an innate need that gives meaning to life (Tharinger & Wells, 2002).

What is RAD?

The fourth edition of the Diagnostic and Statistical Manual (DSM-IV-TR) defines RAD as behavior enacted before the age of five that is disturbed and developmentally inappropriate regarding social relatedness (American Psychiatric Association, 2000; Zeanah, 1996). There are two types of RAD: inhibited type and disinhibited type. A child is diagnosed with either inhibited or disinhibited RAD when he or she consistently fails at responding in manners deemed appropriate during social interactions.

A child is said to be suffering from inhibited RAD when he or she demonstrates behavior considered to be "excessively inhibited," such as attempted isolation or frozen watchfulness of others (Zeanah, 1996). Thus, instead of communicating with others, the child stands still and keeps vigilant watch over those who are around. A child diagnosed with inhibited RAD may communicate through contradictory and highly ambivalent responses, such as either physically approaching or trying to avoid a caregiver. As a result of the associated hypervigilance, a child diagnosed with RAD may also show resistance to being comforted and may also find great difficulty in forming relationships with others (Hornor, 2008).

The disinhibited form of RAD is typically diagnosed when a child partakes in diffuse forms of attachment, as shown by indiscriminate sociability (Zeanah, 1996). This essentially means that the child fails at appropriate selective attachment and shows excessive familiarity, even with strangers, through acts of hugging and kissing. Thus, unlike children with inhibited RAD, children with disinhibited RAD do not partake in hypervigilant behaviors (Hornor, 2008).

To be diagnosed with inhibited or disinhibited RAD under the qualifications of the DSM-IV-TR, a child must have also been subject to pathogenic care, simply defined as care that disregards a child's basic emotional or physical needs (Zeanah, 1996). Thus, diagnostic criteria imply that the form of care a child receives has a direct effect on a child's likelihood to develop RAD.

History of RAD

Abnormal behaviors exhibited by children in orphanages have been documented since the 1950s (Castle et al., 1999). These behaviors include persistent patterns of attention-seeking behavior toward strangers or, contrastingly, complete forms of isolation (Rutter et al., 2007). In the 1970s, caregivers and researchers began to investigate the possibility that such behaviors may be symptomatic of a psychological disorder, as similar acts were being documented in orphanages throughout the world (Glowinski, 2011; Kemph & Voeller, 2008). Eventually, this cluster of behaviors became known as RAD, and was added to the American Psychiatric Association's third addition of the DSM in 1980. Soon after its inception into the DSM III, cases of RAD were diagnosed worldwide, especially among children in orphanages. Follow-up studies began to reveal that symptoms of RAD persisted even after the child's adoption into well-functioning families (Rutter et al., 2007).

Prevalence and Risk Factors

Although RAD is fairly common among children who are institutionalized, it is considered to be a rare disorder worldwide; 1% of children under five years old are diagnosed with RAD (Chaffin et al., 2006; Lake, 2005; Skovgaard et al., 2007). As a result, it is widely believed that RAD disproportionally affects children living in extremely harsh conditions, such as orphanages in developing countries where nutritional, physical, and emotional care are not adequately provided (Zeanah, Smyke, Carlson, & Koga, 2005). RAD affects children in the United States as well and is especially prevalent among children in the foster care system (Zeanah et al., 2004). In the U.S., it is estimated that half of all children adopted from orphanages, along with 40% of children in foster care, are affected by RAD (Barth et al., 2005; Lake, 2005; Zeanah et al., 2004). Such evidence suggests that there are universal underlying factors that influence a child's susceptibility to RAD.

An increasing volume of research links attachment difficulties to neurological dysfunction and underdeveloped brain structures

(Corbin, 2007). Without a consistent and nurturing caregiver, a child is at risk for an underdeveloped brain and consequent neurological deficiencies (Lake, 2005). In such cases, behavior is regulated by survival and biological responses, leaving the child with a reduced ability to regulate emotions, showcase empathy, or form and maintain meaningful relationships.

The deficits in cognitive and social functioning present among children diagnosed with RAD are a result of neglect faced at earlier stages in their development (O'Connor, Bredenkamp, & Rutter, 1999; Stovall & Dozier, 2000). Not only are these children less likely to learn the skills associated with forming appropriate social relations, but they may also lack the cognitive capabilities needed to do so (Lake, 2005). Studies on the link between attachment theory and brain development have found that the absence of a nurturing primary caregiver may result in more aggressive and less emotionally stable brain development (Wimmer, Vonk, & Reeves, 2010).

Full recovery from RAD-related symptoms usually occurs when deprivation from a primary caregiver does not persist beyond the age of six months. It is believed that after six months, a change within the brain structure occurs that results in impaired functioning and delays in cognitive development and physical growth (Kemph & Voeller, 2008). Such social and cognitive deficits are not only linked with RAD, but also place one at risk to develop other long-term mental health maladies such as oppositional defiant disorder, conduct disorder, and adult antisocial personality disorder (Hornor, 2008).

Policy Suggestions

The transactional approach to understanding the development of RAD stresses the importance of a child's attachment to their primary caregiver (Howe & Fearnley, 2003). Without consistent emotional care, children are at risk of RAD, and the effects of RAD usually last well into adulthood (Sigal, Perry, & Rossignol, 2003). Policies should be enacted that prevent or limit the commonality of housing transfers among children in foster care, and more financial and emotional resources should be available

for foster parents in order to ensure adequate provisions for the foster child (Zeanah, 1996). Children in the foster care system indentified with exhibiting symptoms of RAD should be offered mental health care to counter certain psychological effects (Zeanah et al., 2004). Family therapy may help establish an attachment between a foster parent and child. A reduction in household transfers will also help a child feel a sense of support and security (Howe & Fearnley, 2003).

Additionally, psychoeducation regarding the child's behavior may work to reduce the rate of unsuccessful adoptions and thus lessen the prevalence of RAD. The chance of parental emotional withdrawal, which is often a trigger for RAD, is reduced when the parent is aware that their child may respond in a negative and distancing manner when approached with loving and constant care (Howe & Fearnley, 2003). Agencies associated with adoption should be better equipped to provide parents with information about RAD (Judge, 1999; Kaler & Freeman, 1994). With the right treatment, along with a reduction in placement instability and better emotional support procedures in orphanages and foster care facilities, children with RAD may be able to develop and form secure and emotionally fostering relationships.

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