FOSTERING CONNECTIONS: RESPONDING TO REACTIVE ATTACHMENT DISORDER

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• The Feels
OBJECTIVES

• Today participants will learn how to:
• 1. Recognize risk factors and symptoms of reactive attachment disorder
• 2. Explain the relationship between early childhood trauma/impeded emotional development and reactive attachment disorder
• 3. Implement strategies of self-regulation, for both parent/caregiver and child, which will foster connection between parent and child.
• “Humans are neurologically designed, physiologically designed, psychologically, spiritually, emotionally, and cognitively designed, to be in a relationship where you are loved.

• You are designed to take aspects of that relationship inside of you, and they actually become a part of who you are.

• Babies are all need and they cry. So adults must calm them, and the minute we put them down, they start crying again.

• But after we do that a million times, the gap for how long they can tolerate not being held gets wider and wider.

• Because they are taking our love from the outside, and it’s becoming part of them on the inside... Love becomes actual equipment that you take in and walk around with.”

Dr. Henry Cloud
OVERVIEW

What is reactive attachment disorder?

How does reactive attachment disorder develop?

How do I help?
Reactive attachment disorder of infancy or early childhood (RAD) was introduced as a psychiatric condition in DSM-III in 1980.

As defined in 1980, children who experience this condition, which is associated with experiencing severe social neglect during early development have significant difficulties with social relationships.

In 1987 the DSM-III-TR divided RAD into two subtypes—inhhibited and disinhibited.

Children who were inhibited were described as exhibiting internalizing behaviors such as fear, avoidance, and withdrawal whereas children who were disinhibited were described as exhibiting externalizing behaviors such as indiscriminate, superficial sociability.

(Gleason et al., 2011)
The DSM-V (2013) has divided RAD into two separate and distinct conditions:

- Reactive Attachment Disorder (RAD)
- Disinhibited Social Engagement Disorder (DSED).

Despite the significant changes in DSM-V regarding what was known previously as reactive attachment disorder of infancy or early childhood (RAD), there remains consistency regarding the prevalence of these disorders. The different editions of DSM consistently have described these disorders as rare and have suggested that they are most often seen in those who have been reared in deprived, institutional settings.

DSM-V (APA, 2013) notes that fewer than 10% of children who have been severely neglected develop RAD, and about 20% develop DSED (Gleason et al., 2011).
• Reactive attachment disorder is characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance.

• The essential feature is absent or grossly underdeveloped attachment between the child and putative caregiving adults.

(DSM V, 2013)
REACTIVE ATTACHMENT DISORDER - DEFINITION

- Children with reactive attachment disorder are believed to have the capacity to form selective attachments. However, because of limited opportunities during early development, they fail to show the behavioral manifestations of selective attachments.
- That is, when distressed, they show no consistent effort to obtain comfort, support, nurturance, or protection from caregivers. Furthermore, when distressed, children with this disorder do not respond more than minimally to comforting efforts of caregivers.

(DSM V, 2013)
Thus, the disorder is associated with the absence of expected comfort seeking and response to comforting behaviors. As such, children with reactive attachment disorder show diminished or absent expression of positive emotions during routine interactions with caregivers.

In addition, their emotion regulation capacity is compromised, and they display episodes of negative emotions of fear, sadness, or irritability that are not readily explained.

A diagnosis of reactive attachment disorder should not be made in children who are developmentally unable to form selective attachments. For this reason, the child must have a developmental age of at least 9 months.

(DSM V, 2013)
Reactive Attachment Disorder—Diagnostic Criteria

- **Diagnostic Criteria**
- **313.89** A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
  - The child rarely or minimally seeks comfort when distressed.
  - The child rarely or minimally responds to comfort when distressed.

- A persistent social and emotional disturbance characterized by at least two of the following:
  - Minimal social and emotional responsiveness to others.
  - Limited positive affect.
  - Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.

- The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
  - Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
  - Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
  - Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

- The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).

- The criteria are not met for autism spectrum disorder.

- The disturbance is evident before age 5 years.

- The child has a developmental age of at least 9 months.

Specify if:

- **Persistent**: The disorder has been present for more than 12 months.

Specify current severity:

- Reactive attachment disorder is specified as **severe** when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

*(DSM V, 2013)*
REACTIVE ATTACHMENT DISORDER – DIFFERENTIAL DIAGNOSIS

• Autism Spectrum Disorder
• Intellectual Disability
• Depressive Disorders

• (DSM V, 2013)
REACTIVE ATTACHMENT DISORDER- COMORBIDITY

• Cognitive delays

• Language delays

• Stereotypies

• (DSM V, 2013)
Love is a battlefield: The Solomons
DISINHIBITED SOCIAL ENGAGEMENT DISORDER - DEFINITION

• The essential feature of disinhibited social engagement disorder is a pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers.

• This overly familiar behavior violates the social boundaries of the culture.

• A diagnosis of disinhibited social engagement disorder should not be made before children are developmentally able to form selective attachments. For this reason, the child must have a developmental age of at least 9 months.

• (DSM V, 2013)
DISINHIBITED SOCIAL ENGAGEMENT DISORDER-
DIFFERENTIAL DIAGNOSIS

Attention Deficit Hyperactivity Disorder

(DSM V, 2013)
DISINHIBITED SOCIAL ENGAGEMENT DISORDER-COMORBIDITY

- Cognitive delays
- Language delays
- Stereotypies

(DSM V, 2013)
DISINHIBITED SOCIAL ENGAGEMENT DISORDER—DIAGNOSTIC CRITERIA

• Diagnostic Criteria
  • 313.89 A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:
    • Reduced or absent reticence in approaching and interacting with unfamiliar adults.
    • Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
    • Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
    • Willingness to go off with an unfamiliar adult with minimal or no hesitation.
  • The behaviors in Criterion A are not limited to impulsivity (as in attention-deficit/hyperactivity disorder) but include socially disinhibited behavior.
  • The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
    • Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
    • Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
    • Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).
  • The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).
  • The child has a developmental age of at least 9 months.
  • Specify if:
    • Persistent: The disorder has been present for more than 12 months.
    • Specify current severity:
      • disinhibited social engagement disorder is specified as severe when the child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

• (DSM V, 2013)
CASE EXAMPLE

Jessie* was an eleven year old girl who had lived in at least six foster homes and several residential placements by the time I met her. Upon meeting me, Jessie hugged me and wanted to hold my hand. Jessie was in a new foster home and was brought in by her foster mother for behaviors such as storing food under her bed and lying and stealing at school. Jessie had been “kicked” out of several foster homes after “acting out” after a “honeymoon” period with the various families. Jessie’s foster mother was eager to adopt Jessie and wanted to “move the process along quickly”.

Jessie had been severely neglected as an infant and was therefore removed from the home of her biological parents. Jessie had never lived in one place for two consecutive years. Jessie had never formed a secure safe attachment to a caregiver, let alone the first four years of life which were a critical period for secure attachment.

Much to her foster mother’s consternation, Jessie would often verbally acquiesce and then take a different route in her actions. FM could not understand Jessie’s “confusing” behavior and was hesitant about adopting Jessie and let Jessie know that. Needless to say, Jessie’s behavior worsened and that is when she began to see me.

The course of our treatment focused on psychoeducation regarding RAD, DSED and attachment and teaching the family skills, such as noticing, deep breathing and retreating to safe spaces in order to build critical attachment and self regulation skills for Jessie.

*The client’s name has been changed maintain her confidentiality.
HOW DOES RAD AND DSED DEVELOP?

Remember Dr. Cloud’s words?

Humans are neurologically designed, physiologically designed, psychologically, spiritually, emotionally, and cognitively designed, to be in a relationship where you are loved.

We can find some significant answers in neurobiology and neuropsychology.
THE IMPORTANCE OF A NEUROBIOLOGICAL UNDERSTANDING OF EARLY ATTACHMENT

• Dr. Bruce Perry is a psychiatrist and fellow at The Child Trauma Academy in Houston, Texas
• Dr. Bessel van der Kolk, MD at Trauma Center in Boston
• Dr. Dan Siegel, MD at UCLA
• Dr. Pat Ogden, PhD at the Sensorimotor Psychotherapy Institute in Colorado
• Dr. Peter Levine, PhD, Somatic Experiencing Trauma Institute
  • All of these innovators/practitioners/researchers have converged on the important of understanding the neurobiological impact of trauma and neglect
THE NEUROBIOLOGICAL IMPACT OF NEGLECT

• Fig. 2: Impact of neglect on brain development: These images illustrate the impact of neglect on the developing brain. The CT scan on the left is from a healthy three year old child with an average head size (50th percentile). The image on the right is from a three year old child following total global neglect during early childhood. The brain is significantly smaller than average and has abnormal development of cortical, limbic and midbrain structures.

• (Perry, 2008)
THE NEUROBIOLOGICAL IMPACT OF NEGLECT

• “All experience, therefore, changes the brain—even if in the subtlest, microscopic ways.

• Yet experiences in childhood have disproportionate power in shaping the brain.

• Early in life the brain organizes at an incredible rate, with more than 80% of the major structural changes taking place during the first 4 years.

• Experiences that take place during this window of organization have a greater potential to influence the brain—in either positive or negative ways.

• Because the majority of brain growth and development takes place during these first years, early developmental trauma and neglect have a ‘disproportionate influence on brain organization and later brain functioning’”

  • (Perry, 2008)
THE NEUROBIOLOGICAL IMPACT OF NEGLECT

• “Unfortunately, traumatic experiences that take place during this critical window impact the brain in multiple areas and can actually change the structure and function of key neural networks, including those involved with regulating stress and arousal

• Inconsistent, abusive, or neglectful caregiving in early childhood alters the normal development of neural systems involved in both relationships and the stress response.

• It is through patterned, repetitive neural stimulation provided by consistent, nurturing, predictable, responsive caregivers that the infant’s brain receives what is needed to develop the capacity for healthy attachment and self-regulation capabilities.

• The caregiver becomes the external stress regulator for the infant.”

• (Perry, 2008)
SIX CORE STRENGTHS OF HEALTHY DEVELOPMENT

• Neurobiological building blocks:
  • Attachment - the capacity to form and maintain healthy emotional bonds with another person.
  • Self-regulation - The ability to notice and control primary urges such as hunger and sleep, as well as feelings such as frustration, anger, and fear.
  • Affiliation - The capacity to join others and contribute to a group.
  • Awareness/Attunement - Recognizing the needs, interests, strengths, and values of others.
  • Tolerance - The capacity to understand and accept how others are different from you.
  • Respect/Diversity - Appreciating the worth in yourself and in others.
• Remember Dr. Cloud’s words?:

• “You are designed to take aspects of that relationship inside of you, and they actually become a part of who you are.

• Babies are all need and they cry. So adults must calm them, and the minute we put them down, they start crying again.

• But after we do that a million times, the gap for how long they can tolerate not being held gets wider and wider. “
WHAT IS THE KEY TO HELPING THESE CHILDREN...?

CONNECTION
THE QUANDRY

• “Close relationships are the one thing these children avoid.
• Their developmental agenda is to control and not to engage people.
• This denies them exposure to the very experiences they need.
• So long as they remain unable to relinquish control and relate fully and accurately with their carers and therapists, the children make little emotional or developmental progress.”

• Howe and Fearnley (2003)
HOW DO WE HELP?

• A strong detailed developmental history,
• A current assessment of functioning,
• A set of recommendations for intervention and enrichment that arise from the process.

• (Perry, 2008)
WHAT SHOULD THE INTERVENTIONS LOOK LIKE?

• The interventions should meet the child and family where they are with respect to the building blocks.

• A child who is experiencing RAD or DSED will likely be at the attachment phase or self regulation phase.

• The child who is at the attachment phase will need repetitive loving interactions until they have built the neural pathways that will allow them build towards self regulation.

• The child who is at the self regulation phase will need positive repetitive body based movements and experiences that teach them to learn to soothe themselves.
WHAT ARE PROMISING THERAPIES?

Bessel van der Kolk
ARC- Attachment, Regulation, Competency
Trauma Sensitive Yoga
http://www.traumacenter.org/

Pat Ogden
Sensorimotor Psychotherapy
https://www.sensorimotorpsychotherapy.org/faculty.html

Peter Levine
Somatic Experiencing
http://www.traumahealing.org/about-se.php

Bruce Perry
Neurosequential Model (NMT)
http://childtrauma.org/nmt-model/

Expressive and play therapies
Music – drum circles
Art – coloring books
Dance Movement – yoga, dance, ethnic dance
WHAT’S THE REAL WORK TO BE DONE?

• Supporting the parents, siblings…the entire family system
• Psychoeducation for the parents about what they can realistically expect from their child given their neurobiological phase.
• Offering hope to the entire family. By building the blocks of attachment and self regulation parents, caregivers and clinicians are helping to build the neural (brain) pathways.
• Offering a space for the family to make meaning of their current family constellation. That can look like a space to grieve, celebrate, mourn, play, and/or acceptance.
• Teaching parents important skills that can help sustain them through the process of supporting their child, such as:
  • pausing,
  • prayer,
  • meditation,
  • Play,
  • self reflection,
  • deep breathing,
  • self care,
  • seeking appropriate support
NOTE TO PARENTS

• Please know that you are not alone or “crazy”.
• Keep advocating for your family and child and yourself.
• Treat yourself with an extra measure of kindness and grace.
• Connect in ways that bring you positive energy and build your faith.
• Take really great care of yourself.
NOTE TO CLINICIANS

• Believe your clients, both the parents and the children.
• Explore the cadre of body based therapies that are offering new ways of thinking about and treating neglect and trauma.
• Consult and collaborate. As you are offering a great deal of support to families, you too will need support.
• Know when and how to collaborate with clergy supporting your clients’ spiritual needs.
• Take really great care of yourself.
NOTE TO CLERGY

• Familiarize yourself with the role of neglect, trauma and less than optimal attachment in development over the lifespan.
• Know when to recognize the impact of these issues in the lives of your parishioners.
• Connect and consult with clinicians that can help you support the families in your care.
• Know when to refer and collaborate with clinicians who can help meet the mental health needs of your parishioners, as you attend to their spiritual needs.
• Offer consultation to the mental health providers who are supporting your parishioners.
• Take really great care of yourself.
OBJECTIVES

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• Remember Dr. Cloud’s words?

• “Because they are taking our love from the outside, and it’s becoming part of them on the inside... Love becomes actual equipment that you take in and walk around with.”

• Love is always the answer.
And above all these put on love, which binds everything together in perfect harmony.

Colossians 3:14
REFERENCES


