

Reactive attachment disorder research paper examples

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This paper provides an insight on reactive attachment disorder (RAD) that is commonly experienced in children. Symptoms relating to this condition are described in relation to the two types of RAD. In addition, the paper covers the diagnosis and subsequent treatment of the condition. Details regarding epidemiology of RAD are discussed. Consequently, information is provided on how to distinguish RAD from other disorders such as attention deficit hyperactivity disorder, which may have certain similarities to RAD.

Keywords: Reactive attachment disorder, care-giver.

Introduction

Reactive attachment disorder is commonly referred to as RAD. According to Elzouki et al. (2011), reactive attachment disorder is a mental health disorder that affects young children during infancy. Reactive attachment disorder occurs because of unfavorable care given to children. In addition, it is common in children who exhibit excessive behaviors that indicate problems of attachment. Consequently, reactive attachment disorder is characterized by peculiar social behavior (Sadock, Kaplan & Sadock, 2007). This gives an indication of mistreatment that interfered with the development of attachment that is associated with normal child growth. Sadock, Kaplan and Sadock (2007) indicate that according to the Diagnostic and Statistical Manual for Mental Disorders, diagnosis of RAD is based on the environmental deprivation that the child experienced.

Attachment and RAD

According to Shreeve (2011), attachment is a key area that influences RAD. Attachment can be viewed as tendency rather than a behavior. Thus,

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attachment can be defined as a discriminatory interest in a person with whom there is a common sharing of a new experience. This experience is in reference to a past that was shared together. Certain processes related to attachment system play crucial roles during the infancy period of a child. These are the growth of capacity to control emotions and a sense of self (Shreeve, 2011). During the period of 5 to 9 months, the process of separation-individualization occurs, in a child. This is then followed by a period where the child can practice independent actions (9-16 months). During this stage, the child depends on being rescued or being emotionally encouraged while engaging in independent activities. At the age, of 16 months and above, as the child develops independence, risks related to separation become evident.

Proposed Criteria for Linking RAD and Attachment Behavior

Elzouki et al. (2011), suggest that attachment system is triggered when the child is under stress. For purposes of relating the attachment behavior and RAD, certain patterns can be recognized. For instance, an emotionally withdrawal pattern can be portrayed by the child rarely seeking comfort or minimal response when comforted when under distress. In addition, sadness or fear indicates emotional withdrawal. Further, the child may exhibit reduced eye-contact in social settings. In cases, where the child shows indiscriminate pattern, the pattern can be displayed through more than usually familiar behavior around unfamiliar adults, minimal interactions with the adult care-giver and the desire to go with an unfamiliar adult with no hesitation (Elzouki, 2011).

Description of RAD

RAD begins before the child has reached the age of five (Seligman and Reichenberg, 2011). Children who have RAD respond to situations in two different ways. For instance, a child may refuse to engage in any interpersonal encounters. In addition, the child is normally unresponsive. This is commonly referred to as RAD inhibited-withdraw type (Shreeve, 2011). The second type of response that a child may exhibit is RAD disinhibited-indiscriminate type. In this type of RAD, the child is extremely social and seeks comfort from strangers. Children who experience this type of RAD have either been ill-treated or institutionalized (Shreeve, 2011).

Epidemiology

Sadock, Kaplan and Sadock (2007), note that data on RAD in terms of household patterns, sex ratio and prevalence are few. Estimates indicate that RAD affects less than 1 percent of the population. Elzouki et al. (2011) suggest that the prevalence of RAD in clinical samples ranges between 1 and 20 percent. Most of the cases of RAD are because of institutionalization of children. Removal of these institutions reduces any cases of either type of RAD. Studies indicate that, in the United States, 38 percent of children below the age of 4 years that were removed from their homes because of the different kind of abuses showed signs of either inhibited-withdraw RAD or disinhibited-indiscriminate RAD (Sadock, Kaplan & Sadock, 2007). Incidents of RAD are accelerated and are normally associated with certain psychosocial risk factors such as the increase in poverty, dysfunctional families or mental illness of the care-giver.

Symptoms of RAD

Symptoms associated with RAD may sometimes be very confusing. Symptoms are noticeable when a child begins to attend school. The symptoms may include aggression, low self esteem, antisocial behavior or even lack of self-control. In addition, the child may show signs of not trusting anyone, inability to develop relationships with other children. The challenge that arises in recognizing these symptoms is their resemblance to attention deficit hyperactivity disorder. For purposes of distinguishing RAD and attention deficit hyperactivity disorder, RAD is normally associated with compulsive lying, indiscriminate affection with strangers and stealing.

Additionally, children with RAD can become suicidal and destructive. The child becomes manipulative by portraying themselves as victims. A common characteristic of RAD in adolescents is sexual promiscuity. Consequently, the child is not concerned if his or her actions are right or wrong.

Causes of RAD

Children under the age of 36 months are normally at high risk of developing RAD. Some of the causes include physical abuse, emotional abuse or sexual abuse. Additionally marital problems or spousal conflict may contribute to RAD. Cases of marital problems in most situations result to the divorce or separation of parents, which contributes to RAD due to the sudden separation of the child from a care-giver. Children who are mostly in foster homes tend to develop RAD due to the constant moving or changing of homes. Likewise, RAD may be as a result of medical problems associated with child birth. According to Robinson (2002), babies that are born

prematurely are more prone to be affected with RAD. Further, babies that experience feeding difficulties and developmental problems tend to succumb to RAD.

Assessment

First and Tasman (2011), suggest that the best way to assess RAD is through the process of combining both direct behavioral observation and conducting interviews. A detailed history of the experiences the child underwent through are important in finding out what deficiencies caused social abnormalities in the child to be able to carry out the assessment (First and Tasman, 2011). Consequently, the processes of interviews and direct observations need to cover questions about where the child seeks comfort or guidance in times of distress. Furthermore, failure of a child to relate to the care-giver, to seek comfort or display an unfamiliar behavior needs to be identified.

Information on how the child relates to adults or the care-giver in an effort to seek comfort can be obtained in the way the child responds to the interviewer or a different person when with a parent. Consequently, absence of the parent in the interview may trigger the child's attachment system and in the process provide critical information concerning how the child responds when reunited with the parent again. Combination of historical information and direct observations can provide strong support in diagnostic findings.

Differential Diagnosis

First and Tasman (2011) suggest that treatment for RAD should be done according to either inhibited-withdraw RAD or disinhibited-indiscriminate

RAD. Diagnosis for inhibited-withdraw RAD should reflect on the autistic spectrum disorders and mental retardation. Developing children between the ages of 7 to 9 months, experience focused attachment. Therefore, at age 10 and above it becomes possible to distinguish between inhibited-withdrawal from mental retardation since attachment behaviors are absent in inhibited-withdrawal RAD.

Consequently, no diagnosis for RAD should be carried out for children below 10 years since they are not expected to display focused attachment behavior. In cases where the child meets the criteria for Autistic disorder, diagnosis for inhibited-withdrawal RAD may not be done (First and Tasman, 2011). Inhibited-withdrawal RAD can be distinguished from Autism by certain characteristics. In inhibited-withdrawal RAD, there is selective impairment in pretend play, response to joint attention and initiation. Furthermore, a child with this type of RAD does not portray repetitive interests and behaviors common in other developmental disorders (First and Tasman, 2011).

On the other hand, disinhibited-indiscriminate RAD needs to be distinguished from children with high levels of sociability. In addition, for proper diagnosis, a distinction of this type of RAD and attention deficit hyperactivity disorder (ADHD) needs to be done. Disinhibited-indiscriminate RAD differs from ADHD since in cases of impulsivity; RAD is limited to social situations.

Treatment

Despite the lack of a standard treatment procedure for RAD, there are abundant intervention methods that can be implemented as forms of

treatment for RAD. According to Sadock, Kaplan and Sadock (2007), treatment of RAD has to begin with a complete assessment of adequate caregiving and current level of safety. Addressing the child safety as the first priority may assist in making vital decisions such as whether to treat the child while at home or in hospital. In cases where there is physical or sexual abuse, it is essential to report those incidents to the relevant authorities and law enforcement agencies concerned. The physical and emotional state of the child will determine the therapeutic approach to be used. Hospitalization will be necessary in case the child is suffering from malnutrition. Treatment should be focused on changing the undesirable relationship between the child and the care-giver. Consequently, this will require both general and intense education of the care-giver (Sadock, Kaplan & Sadock, 2007).

According to First and Tasman (2011), the primary goal for treating inhibited-withdrawal RAD is to ensure the child develops a focused attachment with the care-giver. In situations like foster homes, the attachment behaviors of a child develop soon after being placed there. In contrast, disinhibited-indiscriminate RAD's main goal of treatment is to boost the child's dependence on caregiving adults or parents and reduce their dependence on unfamiliar adults. In cases where the child has been adopted from an institution, it is advisable to limit their contact with other persons, other than the parents, to ensure that the child develops a selective attachment to them (First and Tasman, 2011).

Studies on the course of RAD in a child indicate a high level of neglect in institutions (Sadock, Kaplan & Sadock, 2007). These studies further indicate

that children with emotional- withdrawal RAD tend to develop normalized attachment behavior when adopted into caring environments. For children with indiscriminate RAD, poor peer relationships are experienced even when introduced into caring environments.

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