Reactive Attachment Disorder: An Evolving Entity

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To put into deserved perspective the contribution that Gleason and colleagues make in this issue of the Journal, theirs is one of the most extensive validation studies to date of reactive attachment disorder (RAD). The investigators sought to validate RAD with approaches derived from the classic 1970 article by Robins and Guze. The study focused primarily on four complementary aspects of validity: construct validity (i.e., is the current description of RAD valid?), discriminant validity (i.e., is RAD different from other disorders?), longitudinal stability (i.e., is RAD stable across time?), and functional impairment (i.e., does RAD impair function as other serious psychiatric disorders do?).

This multifaceted validation attempt is a major step forward. A synthesis of phenomenologic and theoretical perspectives led to the 1980 introduction of RAD in the DSM-III. Clinical descriptions of infants and toddlers exposed to severely deviant rearing environments had long converged to recognize their high risk for certain patterns of emotional-behavioral outcomes, specifically a socially disinhibited/indiscriminate pattern, an inhibited/emotionally withdrawn pattern, and a pattern combining features of social disinhibition and inhibition. RAD subtypes were first described in the DSM-III-R in 1987. By examining the validity of RAD, the study by Gleason and colleagues tackles several enduring controversies: the postulation that a failure and/or absence of a normative attachment process is the core etiologic agent for RAD; that its core dysfunction centers around attachment, which is more theoretical than empirical at this time and thus controversial; the conjectural status of RAD as a bona fide psychiatric disorder; and whether RAD should be separated into two distinct subtypes, which has remained preliminary.

The study uses data from the groundbreaking Bucharest Early Intervention Project (BEIP). Together with other famous studies such as the St. Petersburg Orphanage Study, the BEIP has ushered in an era of serious research on the sequelae of severe deprivation and its mediators and moderators. Orphanages are generally characterized by adverse physical and emotional conditions, where care by too few adults and limited or terse emotional attention or stimulation are normative. The BEIP was launched to investigate the social-emotional-behavioral developmental trajectories and sequelae associated with early institutionalization and to examine whether foster care could remediate or moderate the effects of institutionalization.

For this purpose, 187 Romanian children with a history of institutionalization were screened for participation in a randomized study of institutional versus foster care. Extensive background health and family-of-origin records were often unavailable; thus, the main screening procedure consisted of a pediatric examination to exclude children with obvious syndromes (e.g., fetal alcohol syndrome), neurologic disorders, and/or chromosomal disorders. Such exclusion has allowed a focus on children with a history of pathogenic care but without obviously confounding risk factors. Of the remaining 136 children, half were randomized to continued institutionalization and the other half to foster care. A control group of never-institutionalized children was also enrolled in the BEIP. All children were assessed at baseline, when they were 6 to 30 months of age, at 20 months on average; children were reassessed at subsequent follow-up waves at 30, 42, and 54 months. The assessment battery was state of the art for evaluating toddlers and preschool-age children and included multiple instruments to assess RAD symptoms, attachment security and/or organization, child psychiatric disorders, IQ, caretaker and care environment quality, impulsivity, and child functional impairment. The study used baseline and follow-up BEIP data collected from those children initially randomized to institutional versus foster care, but not from control children. Journal readers might observe that the ethics of randomizing Romanian children to continued pathogenic care versus a hypothetical improved-care condition are complex and, if so, may consider perusing a 2006 commentary on the topic.
The study’s most unique and important contributions to the literature are considered. First, based on these data, the differentiation of two distinct RAD subtypes, characterized by social inhibition and by disinhibition, appears warranted. Second, RAD is distinct from other better-established early childhood disorders, with a particularly clear separation of the RAD-disinhibited subtype from attention-deficit/hyperactivity disorder. A fascinating related subfinding is that the social impulsivity seen in the RAD-disinhibited subtype is a phenomenon quite distinct from the pervasively poor impulse control seen in attention-deficit/hyperactivity disorder. The RAD-inhibited subtype in turn separates from major depressive disorder. However, its symptoms substantially overlap with depressive symptoms in general, and this degree of comorbidity calls for continued prospective study to confirm that this RAD-inhibited subtype is not a depressive disorder. Third, RAD correlates with child functional impairment, even after controlling for key factors such as low IQ. As the authors note, this rebukes the idea that an indiscriminate socialization pattern represents an adaptive set of coping skills in children exposed to institutionalization. Fourth, RAD is at least moderately stable over time (e.g., there is a peak correlation of 0.49 in disinhibited RAD at from 42 to 54 months of age). Importantly, prevalence rates of the disinhibited subtype remain very stable after 30 months, with a prevalence of 18% through 54 months, after a high of 32% at baseline. The inhibited subtype is far less common, with a prevalence ranging from a trough of 1.6% at 42 months of age to highs of 4.6% at baseline and 4.1% at 54 months. Because longitudinal stability was examined only in children randomized to institutional care (to minimize confounds related to changes in caretaking conditions), this validates the enduring pathogenic nature of orphanages but highlights a continued risk of de novo RAD emergence through 54 months of age.

Taken together, these longitudinal results should, ideally, have major international policy implications because a staggering 1 million children currently live in orphanages worldwide. Last but not least, there are critical findings regarding the core conceptualization of RAD. As noted previously, an RAD diagnosis has implied disordered attachment as an etiology and as an outcome. However, the finding that many children with disinhibited RAD show organized attachment patterns at 54 months of age further supports the idea that placing attachment insecurity and/or disorganization at the core of RAD is misguided. This extends previously published BEIP results already challenging attachment as a core substrate for RAD (see Rutter et al. for an extensive commentary). The study also questions another current RAD construct, by showing that concurrent caretaking quality is inversely associated to inhibited RAD but has a minimal relation to disinhibited RAD.

These findings should shape a research agenda to identify novel and/or better predictors of new and/or continued RAD. Related to improved prediction, familial aggregation, a usual hallmark of psychiatric disorders, was shown in 2007, when a large UK twin study reported substantial genetic factors underlying RAD and its two presumptive subtypes. This finding does not invalidate that RAD is a disorder related to environmental deprivation, but rather that such a concept is overly reductionistic. The idea that genetic variations and other currently understudied factors play a role in determining vulnerability to RAD needs to be disseminated and investigated further.

The related clinical take-home message is that we should be weary of over-focusing disinhibited RAD evaluations on attachment patterns and treatment on current caretaking quality. Also, we must remember the variety of risks associated with a wide range of common child behavioral syndromes. RAD diagnoses must be made with parsimony, never reflexively, in adopted and/or fostered patients exposed to deprivation, because these results should be measured against the extraordinary conditions endured by orphanage children.

Regarding the DSM-V, empirical findings support the inclusion of two distinct subtypes of social-emotional-behavioral disorders related to early pathogenic care. Although the inhibited subtype is possibly related to attachment, the disinhibited subtype appears to be a disorder of abnormal social interaction in need of further research and may perhaps benefit from a name change.

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