Attachment disorder is a broad term intended to describe disorders of mood, behavior, and social relationships arising from a failure to form normal attachments to primary care giving figures in early childhood. Such a failure would result from unusual early experiences of neglect, abuse, abrupt separation from caregivers after about age 6 months but before about age 3 years, frequent change of caregivers or excessive numbers of caregivers, or lack of caregiver responsiveness to child communicative efforts. A problematic history of social relationships occurring after about age 3 may be distressing to a child, but does not result in attachment disorder.

The term attachment disorder is most often used to describe emotional and behavioral problems of young children, but is sometimes applied to school-age children or even to adults. The specific difficulties implied depend on the age of the individual being assessed. Thus, no general list of symptoms of attachment disorder can legitimately be presented. The term is not found as such in any standard diagnostic manual such as the DSM-IV-TR, ICD-10, or the Diagnostic Classification: 0-3 [1].

There are currently two main areas of theory and practice relating to the definition and diagnosis of attachment disorder, and considerable discussion about a broader definition altogether. The first main area is based on scientific inquiry, is found in academic journals and books and pays close attention to attachment theory. It is described in ICD-10 and DSM-IV-TR as Reactive attachment disorder, a psychiatric diagnosis of a mental disorder. The second area is controversial has little or no evidence base and makes controversial claims relating to a basis in attachment theory. [2]

Thirdly, some authors have suggested that attachment, as an aspect of emotional development, is better assessed along a spectrum than considered to fall into two non-overlapping categories. This spectrum would have at one end the characteristics called secure attachment; midway along the range of disturbance would be insecure or other undesirable attachment styles; at the other extreme would be non-attachment. (O'Connor & Zeanah, 2003[3]) Diagnostic criteria have not yet been agreed. (Chaffin et al, 2006[4])

Finally, the term is also sometimes used to cover difficulties arising in relation to various attachment styles which are not psychiatric diagnoses or mental disorders.

**Attachment and attachment disorder**

Attachment theory is an evolutionary theory. In relation to infants, it primarily consists of proximity seeking to an attachment figure in the face of threat, for the purpose of survival. Although an attachment is a “tie” it is not synonymous with love and affection. There are two main aspects to attachment behavior. The first is maintaining proximity to another and the second is the specificity of the other (Bowlby 1969, p181). A disturbance of attachment indicates the absence of either or both. This can occur either in institutions, or with repeated changes of caregiver, or from extremely neglectful primary caregivers who show persistent disregard for the child’s basic attachment needs. Current official classifications under DSM-IV-TR and ICD-10 are largely based on this understanding of the nature of attachment.
In the clinical sense, a disorder is a condition requiring treatment as opposed to risk factors for subsequent disorders. (AACAP 2005, p1208[5]) There is a lack of consensus about the precise meaning of the term 'attachment disorder' although there is general agreement that such disorders only arise following early adverse care-giving experiences.

The words 'attachment style' refer to the various types of attachment arising from early care experiences, called 'secure', 'anxious-ambivalent', 'anxious-avoidant', (all organized), and 'disorganized'[6]. Some of these styles are more problematical than others, and although they are not disorders in the clinical sense, are sometimes discussed under the term 'attachment disorder'.

Discussion of 'disorganized attachment' style sometimes includes this style under the rubric of attachment disorders because disorganized attachment is seen as the beginning of a developmental trajectory that will take the individual ever farther from the normal range, culminating in actual disorders of thought, behavior, or mood.

Zeanah and colleagues proposed an alternative set of criteria (see below) of three categories of attachment disorder, namely "no discriminated attachment figure", "secure base distortions" and "disrupted attachment disorder". These classifications retain the basis that a disorder is such as to require treatment.[2]

**Official ICD-10 and DSM-IV-TR classifications**

*Main article: Reactive attachment disorder*

ICD-10 describes Reactive Attachment Disorder of Childhood, known as RAD, and Disinhibited Disorder of Childhood, less well known as DAD. DSM-IV-TR also describes Reactive Attachment Disorder of Infancy or Early Childhood divided into two sub-types, Inhibited and Disinhibited. These are the only formal clinical diagnoses of attachment disorder. The two classifications are similar and both include:

- markedly disturbed and developmentally inappropriate social relatedness in most contexts.
- The disturbance is not accounted for solely by developmental delay and does not meet the criteria for Pervasive Developmental Disorder.
- Onset before 5 years of age.
- Requires a history of significant neglect.
- Implicit lack of identifiable, preferred attachment figure.

There must be a history of 'pathogenic care' defined as disregard of the child's basic emotional or physical needs or repeated changes in primary caregiver that prevents the formation of a discriminatory or selective attachment that is presumed to account for the disorder. Unusually therefore part of the diagnosis is history of care rather than observation of symptoms.

**Boris and Zeanah's typology**

Many leading attachment theorists, such as Zeanah and Leiberman, have recognized the limitations of the DSM-IV-TR and ICD-10 criteria and proposed broader diagnostic criteria. There is as yet no official
consensus on these criteria. The APSAC Taskforce recognized in it's recommendations that "attachment problems extending beyond RAD, are a real and appropriate concern for professionals working with children", and set out recommendations for assessment. (Chaffin et al, 2006[4])

Boris and Zeanah (1999) [7] have offered an approach to attachment disorders that considers cases where children have had no opportunity to form an attachment, those where there is a distorted relationship, and those where an existing attachment has been abruptly disrupted. This would expand the definition beyond the ICD-10 and DSM-IV-TR definitions because those definitions are limited to situations where the child has no attachment or no attachment to a specified attachment figure.

Boris and Zeanah use the term "disorder of attachment" to indicate a situation in which a young child has no preferred adult caregiver. Such children may be indiscriminately sociable and approach all adults, whether familiar or not; alternatively, they may be emotionally withdrawn and fail to seek comfort from anyone. This type of attachment problem is parallel to Reactive Attachment Disorder as defined in DSM and ICD in its inhibited and disinhibited forms as described above.

Boris and Zeanah also describe a condition they term "secure base distortion". In this situation, the child has a preferred familiar caregiver, but the relationship is such that the child cannot use the adult for safety while gradually exploring the environment. Such children may endanger themselves, may cling to the adult, may be excessively compliant, or may show role reversals in which they care for or punish the adult.

The third type of disorder discussed by Boris and Zeanah is termed "disrupted attachment." This type of problem, which is not covered under other approaches to disordered attachment, results from an abrupt separation or loss of a familiar caregiver to whom attachment has developed. The young child's reaction to such a loss is parallel to the grief reaction of an older person, with progressive changes from protest (crying and searching) to despair, sadness, and withdrawal from communication or play, and finally detachment from the original relationship and recovery of social and play activities.

**Problems of attachment style**

Main article: Attachment theory
Main article: Attachment in children
Main article: Disorganized attachment and RAD

The majority of 12-month-old children can tolerate brief separations from familiar caregivers and are quickly comforted when the caregivers return. These children also use familiar people as a "secure base" and return to them periodically when exploring a new situation. Such children are said to have a secure attachment style, and characteristically continue to develop well both cognitively and emotionally.

Smaller numbers of children show less positive development at age 12 months. Their less desirable attachment styles may be predictors of poor later social development. Although these children's behavior at 12 months is not a serious problem, they appear to be on developmental trajectories that will end in poor social skills and relationships. Because attachment styles may serve as predictors of later
development, it may be appropriate to think of certain attachment styles as part of the range of attachment disorders.

Insecure attachment styles in toddlers involve unusual reunions after separation from a familiar person. The children may snub the returning caregiver, or may go to the person but then resist being picked up. These children are more likely to have later social problems with peers and teachers, but some of them spontaneously develop better ways of interacting with other people.

The patterns of attachment used in the research literature are: secure attachment, avoidant attachment, ambivalent attachment, (all organized) and disorganized attachment. The most commonly used procedures for assessing attachment styles in children are the Strange Situation Protocol, various narrative approaches and structured observational methods. A frequently used method of assessing attachment styles in adults is the Adult Attachment Interview developed by Mary Main and Erik Hesse. The relationship between the disorganized pattern of attachment and the clinical diagnosis of Reactive attachment disorder is described in the linked article. Children with disorganized attachment are at higher risk of developing a range of psychopathologies including RAD.

## Assessment and Diagnosis

Recognized attachment measures in children, include:

- Attachment Story Completion Test
- The Strange Situation procedure (Mary Ainsworth),
- the separation and reunion procedure
- Preschool Assessment of Attachment ("PAA", Crittenden 1992),
- Observational Record of the Caregiving Environment ("ORCE")
- Attachment Q-sort ("AQ-sort" [15][16])
- Disturbances of Attachment Interview or "DAI"

## Alternative Diagnosis of Attachment Disorder

Main article: Attachment therapy

In the absence of officially recognized diagnostic criteria the broad term attachment disorder has been used by some to refer to a broader set of children whose behavior may be affected by lack of a primary attachment figure, a seriously unhealthy attachment relationship with a primary caregiver, or a disrupted attachment relationship.(Chaffin et al, 2006[4]) A common feature of this use of the term is the use of extensive lists of "symptoms" which include many behaviours that are likely to be a consequence of neglect or abuse, but are not related to attachment, or not related to any clinical disorder at all.[2]

The APSAC Taskforce Report (2006) describes the issues as follows;
“Many of the controversial attachment therapies have promulgated quite broad and nonspecific lists of symptoms purported to indicate when a child has an attachment disorder. For example, Reber (1996) provided a table that lists “common symptoms of RAD.” The list includes problems or symptoms across multiple domains (social, emotional, behavioral and developmental) and ranges from DSM-IV criteria for RAD (e.g., superficial interactions with others, indiscriminate affection toward strangers, and lack of affection toward parents), to nonspecific behavior problems including destructive behaviors; developmental lags; refusal to make eye contact; cruelty to animals and siblings; lack of cause and effect thinking; preoccupation with fire, blood, and gore; poor peer relationships; stealing; lying; lack of a conscience; persistent nonsense questions or incessant chatter; poor impulse control; abnormal speech patterns; fighting for control over everything; and hoarding or gorging on food. Others have promulgated checklists that suggest that among infants, “prefers dad to mom” or “wants to hold the bottle as soon as possible” are indicative of attachment problems (Buenning, 1999). Clearly, these lists of nonspecific problems extend far beyond the diagnostic criteria for RAD and beyond attachment relationship problems in general. These types of lists are so nonspecific that high rates of false-positive diagnoses are virtually certain. Posting these types of lists on Web sites that also serve as marketing tools may lead many parents or others to conclude inaccurately that their children have attachment disorders.” (Chaffin et al, 2006[4])

Diagnosis
Attachment is fundamental to healthy development, normal personality, and the capacity to form healthy and authentic emotional relationships[17]. How can one determine whether a child has attachment issues that require attention? What is normal behavior, and what are the signs of attachment issues? When adopting an infant, will attachment problems develop? These and other related questions are often at the forefront of adoptive parents’ minds. Attachment is the base of emotional health, social relationships, and one’s world view[18]. The ability to trust and form reciprocal relationships affects the emotional health, security, and safety of the child, as well as the child’s development and future inter-personal relationships. The ability to regulate emotions, have a conscience, and experience empathy all require secure attachment. Healthy brain development is built on a secure attachment relationship.

Children who are adopted after the age of six months are at risk for attachment problems. Normal attachment develops during the child's first two to three years of life. Problems with the mother-child relationship during that time, orphanage experience, or breaks in the consistent caregiver-child relationship interfere with the normal development of a healthy and secure attachment. There are wide ranges of attachment difficulties that result in varying degrees of emotional disturbance in the child. One thing is certain; if an infant’s needs are not met consistently, in a loving, nurturing way, attachment will not occur normally and this underlying problem will manifest itself in a variety of symptoms.
When the attachment-cycle is undermined and the child’s needs are not met, and normal socializing shame is not resolved, mistrust begins to define the perspective of the child and attachment problems result. The cycle can become undermined or broken for many. For example, the signs of difficulties for an infant include the following:

- Weak crying response or rageful and/or constant whining; inability to be comforted
- Tactile defensiveness
- Poor clinging and extreme resistance to cuddling: seems stiff as a board
- Poor sucking response
- Poor eye contact, lack of tracking
- No reciprocal smile response
- Indifference to others
- Failure to respond with recognition to parents
- Delayed physical motor skill development milestones (creeping, crawling, sitting, etc.)
- Flaccidity

**Treatment**

There is a variety of prevention programs and treatment approaches for Reactive attachment disorder and other attachment difficulties.

1. 'Circle of Security' (Marvin et al, 2002)
2. Dyadic Developmental Psychotherapy
3. 'Watch, wait and wonder' (Cohen et al, 1999),
4. manipulation of sensitive responsiveness, (van den Boom 1994 and 1995),
5. modified 'Interaction Guidance' (Benoit et al, 2001),
8. Developmental, Individual-difference, Relationship-based therapy (DIR) (also referred to as Floor Time) by Stanley Greenspan, although DIR is primarily directed to treatment of pervasive developmental disorders.

**See also**

- Attachment theory
- Attachment therapy
- Bowlby
- Disorganized attachment and RAD
- Dyadic Developmental Psychotherapy
- Reactive attachment disorder
- Stanley Greenspan
- Theraplay
References

1. ↑ Diagnostic Classification: 0-3 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Zero to Three National Center for Infants, Toddlers, and Families, Washington, DC, 2002
6. ↑ Ainsworth, M., (1978), Patterns of Attachment

Additional Reading and References

- O'Connor and Zeanah (2003) "Attachment disorders and assessment approaches Attachment and Human Development 5(3)223-244:Taylor and Francis