

Reactive Attachment Disorder: A Review

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Attachment is often defined along the same lines as love. It is an emotion or commitment that we feel for another person. Love and attachment begin to develop soon after birth and they continue throughout persons' lives (Maroney, 2001). Unfortunately, the dance between a child and parent can be disrupted and eventually lead to problems with attachment and ultimately love.

Prevalence numbers for disorders relating to attachment are unclear. Attachment disorders are commonly misunderstood and under-diagnosed. Although the symptoms begin early, they often become pervasive throughout life. By the time they are recognized, the disorder may resemble many others (Sheperis, Renfro-Michel & Doggett, 2003). Although a substantial amount of research has been reported on attachment between parents and infants, few researchers have examined the disorder that results when the attachment process is disturbed.

Using recent research, this paper will provide an overview of reactive attachment disorder, its symptoms, characteristics and causal factors, as well as assessment and treatment tools. It will conclude with a discussion of controversies relating to the present DSM-IV definition as well as attention to prevention considerations.

Theories of Attachment

In the 1920s there were many theories about the psychology of raising children. The prominent behavioral psychologist, John B. Watson, developed a theory that changed the way parents nurtured their children. He "contended that children were completely a product of their environment, and that too much spoiling by parents could be dangerous" (Maroney, 2001, p. 66). This theory became well accepted by the public and it led to children being left alone and told to be quiet. Two decades later, however, John Bowlby developed the theory of attachment that emphasized the importance of the relationship between a mother and her infant. His theory has

since been confirmed and it is now realized that this bond impacts our ability to develop quality relationships throughout our life (Maroney, 2001).

Bowlby's theory of attachment is based on biology and evolution. In this survival theory, "attachment behaviors serve to increase the proximity of the child to the parent...which increases the chance of survival by eliciting parental protection"(Robinson, 2002, p.7). In 1969 Bowlby (as cited by Wilson, 2001) proposed four phases of the attachment behavioral process:

1. Phase 1 (birth to 3 months): It is the caregiver's responsibility to maintain proximity to the infant. The infant signals the need by crying and maintains the proximity by rooting, sucking and grasping.
2. Phase 2 (3 to 9 months): The infant becomes more of an active participant in the attachment. The infant will signal a preference for a caregiver by smiling, vocalizing, scooting and reaching.
3. Phase 3 (9 months to 4 years): Infants become increasingly wary of unfamiliar adults. The infant will begin to use the caregiver as a secure base for exploration. This safe haven is where he/she seeks physical or emotional reassurance. During this stage, the child expects reasonable consistency and will begin to anticipate the caregiver's behaviors.
4. Phase 4 (4 years +): In this stage there is the development of an understanding of the caregiver's independence. The child can read motives and feelings. The relationship becomes a partnership. There are still attachment behaviors but they are based on shared goals, plans and feelings.

In 1978 Ainsworth and her colleagues moved beyond Bowlby's theory. They introduced "the concept of caregiver sensitivity to infant signals and the role of this sensitivity in the

development of attachment patterns”(Wilson, 2001, p.38). Using what is referred to as “the strange situation”, they developed a method for assessing the quality of attachment. This laboratory procedure defines the attachment pattern in relation to the infant’s response to reunion with the caregiver. Infants fall into three distinct patterns: secure, insecure/resistant and insecure/avoidant (Wilson, 2001). The combination of Bowlby’s attachment theory and the results of the strange situation opened the door for research into infants and adolescents who present attachment problems.

Reactive Attachment Disorder

In the late 1970s and early 1980s, clinicians and researchers began to recognize that children who “experienced abuse, neglect, or frequent disruptions in primary caregivers often exhibit varying degrees of cognitive, physical and social-emotional delays” (Richters & Volkmar, 1994, p.328). After several revisions, the current diagnosis of reactive attachment disorder (RAD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) characterized RAD by “markedly disturbed and developmentally inappropriate social relatedness in most contexts” (Zeanah, 2000, p.1). DSM-IV also explained that this disorder is due to “pathogenic care”, such as maltreatment, or frequent changes in primary caregiver, that the disorder must begin before age five, and that it cannot be solely due to developmental delay or pervasive development disorder. The current diagnosis of RAD does not apply to all children who fit the patterns of anxiously or insecurely attached. Rather there is a graded continuum of attachment problems with significant ones representing a subgroup of insecurely attached children (Wilson, 2001).

DSM-IV distinguishes two types of reactive attachment disorder. The *inhibited type* is characterized by a failure to appropriately initiate and respond to social interactions. These

children may tend towards avoidance behaviors (Wilson, 2001). Zeanah (2002) described children with the inhibited type as lacking the tendency to initiate or respond appropriately during social situations. They may be hypervigilant or highly ambivalent. The *disinhibited type* is more related to social promiscuity. The child may be overly social in inappropriate ways and settings (Wilson, 2001). Children who are diagnosed with this subtype are “marked by a lack of selectivity in choosing those from whom to seek comfort, support and nurturance, resulting in a peculiar ‘overfriendliness’ with relatively unfamiliar adults that has been labeled *indiscriminate sociability*” (Zeanah, 2000, p. 1).

Symptoms and Characteristics

The symptoms associated with reactive attachment disorder may confuse many mental health counselors. Sheperis, Renfro-Michel, et al. (2003) explain how symptoms appear very similar to other childhood disorders and therefore RAD may go undiagnosed. Infants who are exhibiting a weak crying response, tactile defensiveness or a failure to thrive may signal an alarm. However, many symptoms may not be noticed until the child begins school. These symptoms include low self-esteem, lack of self-control, anti-social attitudes, and aggression. Teachers and other adults may also notice a lack of ability to trust, show affection or develop intimacy. Children diagnosed with reactive attachment disorder may also have a difficult time processing cause and effect relationships. All of these symptoms are often mistaken for attention deficit hyperactivity disorder (ADHD), especially in the school setting. Behaviors that may set reactive attachment disorder apart from ADHD are compulsive lying and stealing, sexual behaviors, and indiscriminate affection with strangers (Hall & Geher, 2003).

There are often severe behaviors associated with this disorder. Children can become self-destructive and suicidal. They may either be overtly aggressive or passive-aggressive and

destruction of property and fire setting may be prominent. Often these children are ingeniously manipulative and perceive themselves as perpetual victims. As adolescents, children with reactive attachment disorder, who have not received treatment, may end up with distorted body images, severe aggressive behaviors, and sexual promiscuity. Finally, they may lack remorse for their own behaviors and not demonstrate a concern for right and wrong (Sheperis, Renfro-Michel et al., 2003).

Causal Factors

Because the symptoms of reactive attachment disorder may resemble other childhood disorders, knowledge of the child's history is crucial. To date, research has failed to uncover a specific organic etiological component. Rather it is conceptualized that reactive attachment disorder is caused by pathogenic care during infancy. Often referred to as maltreatment, this pathogenic care can consist of abuse, neglect, and frequent changes in a primary caregiver, or severe unrelieved pain (Hall & Geher, 2003). "The process of growth and development in these children is disrupted by psychological elements resulting from the lack of attachment with the primary caregiver" (Hall & Geher, 2003, p. 145).

The positive interaction between infant and caregiver needed for the attachment process is absent in the lives of these children. Yet, attachment patterns lie on a continuum and while abuse may be at one end of the spectrum, there are other childhood situations that can lead to disruption in the attachment process. A caregiving style that lacks attuned, sensitive and empathic nurturing has also been found to lead to attachment problems. There are a number of risk factors that increase the chance for attachment problems. These include marital problems, spousal abuse, early loss or trauma, parental states of mind and poverty. Even with such risk factors, there are also resilience factors that affect psychological outcomes. However, research

has shown that the length of early deprivation relates to the severity of the attachment problems (Robinson, 2002).

Many of the studies that have been conducted relating to attachment problems have been performed using children adopted out of Eastern European (primarily Romanian) or Russian institutions. Smyke, Dumitrescu and Zeanah (2002) completed such a study and concluded that when children were raised in environments that limited opportunities for them to form attachments, they were far less likely to develop them. With this longitudinal study, they were also able to see that even after adoption and apparent attachment to a caregiver, the children continued to display indiscriminate behaviors.

Certain child-related factors also can heighten attachment problems. Pre-term and low birth weight babies are more prone to attachment difficulties, possibly due to parent-child separation and related medical problems. Infants with difficult temperaments, lengthy medical illness, difficult feeding issues, hearing impairments, and developmental disabilities are also at risk for developing reactive attachment disorder (Robinson, 2002).

Assessment and Identification

Reactive attachment disorder affects more than just the individual child. Family members of children with the disorder may find themselves unable to deal with the problem behaviors. Parents are often unable to protect other children and family pets from the dangerous actions of children with the disorder. Schools face the dilemma of how to educate these children. School personnel attempt coincidentally to manage behavior and focus on academics. But because children with reactive attachment disorder tend to “act out, bully, scare, and harm other children” (Hall & Geher, 2002, p.20), they may have trouble functioning both in general and

special education classrooms. There is also a tendency for these children to drift towards other antisocial children, establishing dangerous associations (Hall & Geher, 2003).

Because of the severity of the impact on families, schools and society, early identification of the disorder is crucial. However, as of yet there is “no comprehensive procedure to assess a child for reactive attachment disorder, [instead commonly used are] a battery of semi-structured interviews, global assessment scales, attachment-specific scales, and behavioral observations” (Sheperis, Doggett, et al., 2003, p. 291) have been proposed to help identify the disorder. The basis for the diagnosis is two distinctive components: (a) a description of the deficits in social development, and (b) a knowledge of the pathological familial background (Sheperis, Doggett, et al., 2003).

Because the DSM-IV requires a pathological basis for diagnoses, a detailed family history is a requirement. Research in the areas of infant-caregiver relationships, adoption, and child abuse and primate relationships have supported the relationship between an absence of meaningful attachment at an early age and subsequent attachment disorders. Hall and Geher (2003) compared histories and behaviors of children diagnosed with reactive attachment disorder to those without the diagnosis. The researchers reported on the connection between faulty attachment patterns and atypical, sub-optimal family structures. Therefore, an extensive psychosocial history should be taken including, “current referral concerns, biological parental history, medical history, developmental history, mental health history, school history, disciplinary practices and legal and victim issues”(Sheperis, Doggett, et al., 2003, p. 298). It is also essential to conduct clinical interviews of both the guardians as well as the child.

A number of assessment instruments are available to assist mental health professionals with diagnosis and differentiation between sub-types. Sheperis, Doggett, et al. (2003) identify

the most useful rating scales in making the diagnoses. The Child Behavior Checklist (CBCL) was designed to assess children and adolescents for abilities and behavior problems in a standardized format. It provides information on the general behavior of the child and can provide insight to the presence of internalizing or externalizing factors. The Behavior Assessment System for Children (BASC) is used to assess children and adolescents for emotional and behavioral disorders. Often used in schools, it can distinguish a child's pathological thinking from that of normal peers. The Eyberg Child Behavior Inventory (ECBI) and the Sutter-Eyberg Student Behavior Inventory—Revised (SESBI-R) are used to determine the severity of conduct problems. This scale focuses on the intensity of behaviors and can be used to measure change due to treatment. While these scales may be useful in identifying behaviors and thoughts, they are also used for many other childhood mental disorders. Without an adequate history and more specific behavioral observations, they can lead to misdiagnosis.

Two scales directly related to attachment have been developed in recent years. The Reactive Attachment Disorder Questionnaire was normed in Europe and may present generalization problems in the United States. However, the Randolph Attachment Disorder Questionnaire (RADQ) has shown promise in discerning “children with attachment problems from those with a disruptive behavior disorder”(Sheperis, Doggett, et al., 2003, p. X). The RADQ has not been independently analyzed and does not assess sub-types of insecure attachment patterns. Further the authors recommended that it not be used as the sole diagnostic device. Instead it should be used along with the other above-mentioned scales to provide a clearer profile of a child's disorder (Sheperis, Doggett, et al., 2003).

Another important component of the diagnosis of reactive attachment disorder comes in the form of direct behavioral observations. These observations are consistent with that of a

functional behavioral assessment, which serves as a useful tool in determining the purpose behind specific behaviors. Used along with parent management training literature, one may be able to use analogue observations of familial interactions to delineate task avoidance from social avoidance. This can be crucial in separating reactive attachment disorder from other behavioral disorders in children (Sheperis, Doggett, et al., 2003).

Treatment and Outcomes

When “infant and toddler basic needs are not conducted in a consistent fashion, attachment becomes disrupted, causing difficulty in the conditioned response to rely on human relationships.... Chronic inconsistency in meeting infant and toddler needs as well as the introduction of early childhood trauma...is linked to psychiatric syndromes, criminal behavior and drug use”(Sheperis, Renfro-Michel, et al., 2003, p. 76). Therefore intervention is imperative and the earlier diagnosis is made, the earlier treatment can begin. Because the basis of the disorder is related to social-emotional development (vs. neurobiological defects), it is felt that the condition is responsive to treatment (Richters & Volkmar, 1994). Currently there is no set treatment protocol, yet there are numerous attachment-related interventions being practiced. However, few of them have clear empirical support or are conducted by trained professionals (Robinson, 2002). Just as there are various forms of attachment problems and causal factors, there are numerous methods of treatment, all dependent on the age of the child and the severity of the problem.

When identification at an early age is made, direct work with caretakers to promote attachment-related parenting skills and a nurturing, safe environment can be done. Often this early intervention shows success when supportive therapy for the mother is provided. Robinson (2003) discussed several studies that reported that, although infant attachment increased,

maternal sensitivity did not. Yet, follow-up observations at age three revealed enduring effects of the treatment. Robinson also discussed a number of studies with mixed results among high-risk populations, yet data suggest that the interventions are promising. Along with supportive therapy, in-home psychotherapy for the parents has also been shown to be successful in decreasing pathological parenting.

Another area for study has been interventions for children in adoptive or foster homes. Multiple placements and lack of early attachment with a primary caregiver can lead to children developing maladaptive behaviors, such as indiscriminant social skills and aggressive behaviors. These behaviors are thought to be associated with survival needs. Without a primary caregiver to provide necessary support and protection, children in group homes, large foster homes or orphanages may have to vie with other children for affection, food and toys (Smyke et al., 2002). Mixed results have been obtained from these studies. Whereas attachment may actually increase, by a certain age, the indiscriminant behaviors continue. These effects are linked to the continuum of caretaking causality. It is unclear “how much recovery is possible for such children and what characteristics of the child and environment increase the likelihood of recovery” (Smyke et al., 2002, p. 979).

Once a child has begun school and social behaviors become more of an issue, intervention becomes more necessary and controversial. Reactive attachment disorder and its presence in school-aged children can be an indication of future pathological disturbances and therefore the treatment is of critical importance (Wilson, 2001). Yet, children with reactive attachment disorder can be resistant to conventional therapies. The barriers to therapy are the child’s “inability to profit from experience, minimal desire for change, little or no regard for authority and poor impulse control” (Wilson, 2001, p. 42).

Residential intervention is a choice of treatment for many mental health professionals. One of the most well-known, and yet controversial, centers is the Attachment Center at Evergreen, Colorado. Wilson (2001) explains that this center uses a multidisciplinary team consisting of “therapists, therapeutic foster parents, psychiatric consultants, a clinical director and a hometown therapist who does the initial placement”(p. 47). The therapy consists of cognitive re-structuring, re-parenting, psychodramas, and trauma resolution. This attachment center, along with some others across the country, uses as a component, a controversial therapy called holding therapy. This holding therapy may also be called rebirthing or rage-reduction therapy. The goal is to recreate the bonding cycle that an infant experiences. Components of this therapy include: “prolonged restraint, prolonged noxious stimulation, and interference with bodily functions such as vision and breathing” (Robinson, 2002, p. 12). A therapist forces the child to maintain eye contact while the child’s arms and feet are restrained. The therapist invokes inner rage from past experiences by using confrontational dialogue. There is supposedly nurturing feedback throughout the session and the intent is to release the inner rage to allow for the forming of a healthy attachment (Wilson, 2002).

There are numerous critics of holding therapy. It has been linked to brainwashing and called cruel, unethical and dangerous. Many claim the benefits are based on fear. After the death of a 10 year-old girl undergoing a “rebirthing” procedure, many states banned the procedure. However, the practice continues at many private attachment centers across the country (Robinson, 2002). Holding therapy has not been empirically validated and there is limited research on the effectiveness of residential treatment as a whole. While in some studies children have shown a reduction in aggression and delinquency behaviors after treatment in these facilities, no long-term studies have been done (Wilson, 2001).

Appropriate interventions should be evaluated. The first and most important component of any intervention should be to provide a caregiving relationship. This should come from an emotionally available, sensitive and responsive, parental figure to which attachment can develop (Robinson, 2002). Part of the therapeutic task is to help the child or adolescent set attainable goals. Prior to that though, the child must be ready to change. Therapeutic Foster Care has been shown to be an effective mode of treatment for attachment disorders. Therapy is provided by the parent figures as well as brought into the home several times per week by a therapist. Therapists work on impulsivity, hyperactivity, anger management, boundaries, and abuse-related issues. These therapeutic foster homes are often a last resort before residential placement. The sterility of such facilities feed directly into the nature of reactive attachment disorder and the children are not challenged by intimacy. There is prolonged lack of contact with caregivers, which can lead to worsening of behaviors associated with the disorder. Any therapist considering institutionalization must carefully weigh the consequences (Sheperis, Renfro-Michel, et al., 2003).

Hanson and Spratt (2000) have suggested that treatment of reactive attachment disorder should include “(a) proper diagnosis at an early age; (b) placement in a secure and nurturing environment; (c) instruction in empirically based parenting skills; (d) emphasis on family functioning, coping skills, and interaction as opposed to focusing on vague pathologies; and (e) working with the child’s and family’s more naturalistic environments as opposed to more restrictive and intrusive settings” (p.140).

The futures for children with reactive attachment disorder are mixed. Just as the causal factors and treatments differ, so do the outcomes. Many adolescents with reactive attachment disorder “voice a desire for things they cannot affectively or cognitively manage such as strong

friendships and intimacy” (Sheperis, Renfro-Michel, et al., 2003, p. 79). They may sabotage future relationships because love and intimacy scare them. It is noted that indiscriminate sociability persists long after children develop attachment figures in adoptive homes. This indiscriminate sociability predicts subsequent peer relational difficulties later in life (Zeanah, 2000). As these children get older they “develop various attachments styles in the attempts to cope” (Richters & Volkmar, 1994, p. 332) with their inconsistent understanding of attachment and intimacy. Wilson (2001) discusses several studies that directly link attachment problems in infancy with later psychiatric diagnoses. Wilson also refers to a study conducted by Rosenstein and Horowitz in 1996 that found out of 60 adolescents admitted to a psychiatric hospital, 97% reported feelings related to insecure attachment.

Without treatment, one can predict a possible continuance of criminal behavior due to the lack of remorse and compassion for others’ that develops over time. Adolescents gain a grandiose sense of self-importance where only their wants and needs matter. Eventually their consciences may be marked by the enjoyment of others physical or emotional pain (Sheperis, Renfro-Michel, et al., 2003).

Discussion

The current diagnostic criteria for attachment disorders are criticized by a number of researchers. Robinson (2002) stated that the current criteria “limit the scope of attachment theory application by relying on ill-defined pathogenic etiology and fails to address the full spectrum of the disorder” (p. 10). There have been proposed alternative sets of criteria that better describe the broad range of disturbances but as of yet these criteria are usually only applied to research (Robinson, 2002). One specific complaint is that the present criteria focus on

behavioral concerns rather than patterns of attachment. However, it is the behavioral concerns that are most relevant throughout the lives of the affected children. These children tend to display common maladaptive behavior problems and those areas of need are much easier to identify than lack of attachment (Hall & Geher, 2003).

Another area of concern is how reactive attachment disorder “symptomatology mimics that of many childhood disorders”(Sheperis, Renfro-Michel, et al., 2003, p. 291). The behaviors associated with RAD are closely related to those of conduct disorder, oppositional defiant disorder and ADHD. Because of this, reactive attachment disorder may often be overlooked as a possible diagnosis (Sheperis, Doggett, et al., 2003). The related behaviors of all these disorders are often precursors to the most treatment-resistant type of disorder—antisocial personality disorder. Due to the severity of this disorder, researchers are pressuring mental health professionals to recognize the early onset of reactive attachment disorder and to provide treatment as soon as possible (Sheperis, Doggett, et al., 2003). According to Hanson and Spratt (2000), the purpose of the diagnosis is to address the issue of a child’s ability to relate to others. Many of these children’s problems are caused by abnormal, social behaviors, developed in the context of pathogenic care in infancy. Because both behaviors and attachment patterns are integral to the diagnosis, it may be appropriate to address both behavioral difficulties and to explore attachment patterns.

Another group of affected children may not experience abuse, neglect or a change in caregivers. These children are born with developmental disabilities or other medical conditions that stand in the way of the parent or the child creating that attachment bond. The separation of infant and parents due to hospitalization, or other extended separations over time, can contribute to interruptions in the attachment process (Wilson, 2001). Another example could include “a

premature infant who has developmental delays may not smile at the typical four to six weeks age, she may not be able to coo, clap her hands, or even sit on the floor and play” (Maroney, 2001, p.1). Therefore the baby may not be able to express her needs and the parent may have difficulty understanding her cues. If the mother or the baby does not respond as expected, the attachment process may be interrupted (Maroney, 2001). A child with a severe disability may be overly dependent on the parent beyond feeding, playing and holding. If this is the case, the parent may have the dual roles of parent and nurse that can confuse both parent and child (Maroney, 2001). Children that fall into this category would not qualify for the diagnoses of reactive attachment disorder under the current DSM-IV criteria. However, infants with special needs are also at more of a risk for abuse and neglect (Wilson, 2001) that may result in meeting the pathogenic care criteria.

Because the causal factors of reactive attachment disorder are usually related to social, emotional and environmental issues, primary prevention is straightforward. Parents should be taught, and then should provide, sensitive, responsive nurturing of infants and children, although this is easier said than done in many cases. Recognition of risk factors is the first step towards providing education and support. Caregiver characteristics that demonstrate risk factors include depression, isolation, lack of social support, poverty, and their own abuse during childhood (Wilson, 2001). It appears that any measures put in place to prevent abuse and neglect would apply also to reactive attachment disorder.

Secondary prevention would begin as soon as symptoms are noticed and takes the form of early intervention. Parents are provided direct instruction in caretaking responsibilities and how to understand their child’s needs. Therapy should also be provided to address the underlying cause of the parent’s lack of nurturing.

For children awaiting adoption, extreme caution should be taken when providing care. Smyke et al. (2002) found that when children in Romanian orphanages had contact limited to only a few caretakers, they were better able to establish a preference for someone. These children then benefited from attaching to that preferred caregiver.

Children in foster care are possibly the most at risk. Foster parents need to be trained in how to create that bond with children who are at risk for developing attachment disturbances.

Because attachment is so crucial to a child's well-being, parents of children with special needs likely will require special attention from therapists and other professionals. These parents may need to realize that their child will have his own way of communicating needs. From the moment the child arrives home, parents must learn how to read non-verbal language and body patterns. It is in this area that supports from healthcare providers and early childhood special educators can be especially useful.

Reactive attachment disorder is a challenging, perplexing problem facing children and families. The key for parents is to make their child feel as if he is at the center of the universe and that no matter what happens, the parent will always be a safe harbor.

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