Attachment "Disorders": Capitalizing on Misfortune

Lynda R. Ross, Associate Professor Women's and Gender Studies, Centre for Interdisciplinary Studies, Athabasca University, also coordinates the University Certificate in Counselling Women program. She graduated with a doctoral degree in Psychology from the University of New Brunswick in 1998. Her research interests centre on the construction of theory and "disorder," attachment, and motherhood.

Abstract
Attachment theory is the primary source informing Reactive Attachment Disorder (RAD) as well as providing the framework for other potential "attachment disorder" diagnoses. This paper provides an historical overview of the RAD construct and discusses the personal and social implications resulting from "disordering" conduct and separating normal from patho-logical behaviours.

Résumé
La théorie de « l'affection » est la source principale d'information du Trouble réactionnel de « l'affection » (TRA). Elle fournit également le cadre pour d'autres diagnostics de « troubles affectifs » potentiels. Cet essai fournit un survol historique sur la façon dont le TRA construit et amène des discussions sur les implications personnelles et sociales résultant de la conduite trouble, tout en séparant les comportements normaux des comportements pathologiques.

> [I]f we are to get at least a conceptual grip on those pervasive and intractable aspects of human suffering that are of our own making, we are going to have to struggle with the ways in which power and interest shape the material conditions of our lives as well as the structures of meaning that filter our understanding of our plight. (Smail 2008, 139)

The consequences of "disordering" conduct created by the socio-economic-political environments in which we ask people to live are grave not only for individuals but also for the moral fibre of our societies. Reactive Attachment Disorder (RAD), like so many of the "disorders" in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), focuses attention on individual behavioural and emotional deficits, drawing awareness away from the broad social-political-economic conditions in which "disorders" develop and are sustained. An RAD diagnosis serves to undermine the need for economic reform while privileging socially constructed notions of normality that decrease tolerance for individual differences. Paradoxically, the distress seen in children suffering from RAD is real. As such, the diagnosis may serve the needs of individual children through clinical attention to both their "symptoms" and to altering the contexts in which they live. Thus, while this paper offers a critique of the RAD construct, it does so fully recognizing children's vulnerability to devastating conditions and to the profound effects negative circumstances may have on their physical, cognitive and emotional well-being. This critique is not asking that we ignore the impact of abuse. It asks instead that we acknowledge the devastating consequences that result from poverty and abuse, and in so doing, develop solutions that are framed within a social reform perspective. While RAD is the only attachment "disorder" appearing in the *DSM*, the ubiquitous use of the term "attachment" in the clinical and popular

literatures suggests that “attachment disorders,” both in childhood and adulthood, will soon find their way into the nosology of the *DSM*, expanding once again what societies are asked to accept as “disordered” behaviours.

What follows is a brief overview of attachment theory as the primary source informing the RAD construct. The theory also provides the framework for a potential and broadly defined “attachment disorder” diagnosis. An historical review of the construct's development is offered as a way to situate discussions about concerns with its diagnostic criteria, as well as with the personal and social implications resulting from “disordering” attachment conduct. The concluding section offers a brief and general critique of the *DSM*, focusing on dichotomies that separate normal from pathological behaviours.

Grounding RAD in Attachment Theory

In the broader literature, attachment theory has shaped understandings about the course and consequence of intimate human relations across the life span (Bowlby 1969; 1973; 1980). Internal Working Models (IWMs) were conceptualized as active cognitive “maps” governing memories, knowledge, perceptions, expectations, behaviours, and affects of self and other(s) in all attachment relationships. They were proposed as the mechanism determining the way individuals would function in all—present and future—attachment relationships. Developing in infancy and early childhood, IWMs were hypothesized “to persist relatively unchanged throughout adult life” (Bowlby 1977, 141). Persistence, combined with the idea that IWMs operate at an unconscious level, contributed to earlier understandings that once attitudes about self, attachment figure(s), and the interactions between them are “... woven into the fabric of the working models, they are apt hence-forward never to be seriously questioned” (Bowlby 1973, 205). By evaluating a balance between attachment behaviours (e.g., proximity-seeking) and those antithetical to attachment (e.g., exploration) Mary Ainsworth and Barbara Wittig (1969) isolated and measured three distinct infant attachment styles. These styles defined the strength and quality of infants' attachment to their caregivers.

Underlying the classification of infant attachment styles was John Bowlby's concept that infants use their caregiver as a “secure base” during times of distress (Bowlby 1958; 1969). As such, infant attachment styles develop in direct response to the ways in which primary caregivers (often defined as the mother) manage their infants' attempts at proximity seeking. Thus, appropriately responsive, consistently available, and ever sensitive caregivers become responsible for “secure” infant attachment outcomes. Alternatively, inappropriate caregiving results in negative outcomes for the infant in the form of “insecure” models of attachment. Infants classified as “secure” are described as being able to express their anger and fear of separation, while still able to explore novel surroundings. They can also be readily comforted when re-united with their caregiver(s). In contrast, those classified as “avoidant,” although appearing unconcerned about separation, show signs of physiological arousal for longer periods of time compared to infants classified as secure. They also resist being comforted by their caregivers when re-united. Infants classified as “ambivalent” show the same levels of arousal as “avoidant” infants, but tend to respond to reunions with undue and exaggerated demands for attention and with clinging behaviours (Ainsworth et al. 1978).

Over the past four decades, these infant attachment style categories have remained largely unchallenged. A fourth, “disorganized-unresolved” (Main and Solomon 1986) was introduced to capture the behaviours of infants who appear confused and display no organized strategy for handling reunions (Main and Hesse 1990). Using these classification categories, between 57–73% of infants are described as “secure,” leaving the balance to be labelled as insecure (avoidant or ambivalent) or disorganized-disoriented (Main and Solomon 1986). These attachment styles were typically viewed as descriptors of infant-caregiver interactions and the somewhat fixed

cognitive strategies with the potential to influence future relational outcomes. They were also viewed as playing a powerful role in mediating a variety of psychopathologies (Green and Goldwyn 2002). From a description of cognitive coping strategies used to navigate interpersonal relationships, the "secure" style has now become the privileged benchmark defining "normal" healthy relationship functioning.

Reactive Attachment Disorder

Reactive Attachment Disorder (RAD) highlights problems in a child's ability to function in and benefit from attachment relationships. It made its first appearance in the *DSM* nosology in 1980 (APA 1980). RAD was a response to findings from a sparse literature emerging from the study of institutionalized children exposed to severe maltreatment and extreme deprivation (Bakwin 1949; Bowlby 1944; Provence and Lipton 1962; Rutter 1972; Skeels and Dye 1939; Spitz 1945; Tizard and Hodges 1978; Tizard and Rees 1975). In the first iteration of RAD, failure-to-thrive was used as an important defining criteria (Harris 1982). Dating back to the late 1800s, a failure-to-thrive diagnosis helped make sense of physical and emotional deficits resulting from severe sensory deprivation and malnutrition (Olsen 2006; Schwartz 2008). By contrast, the early works of attachment theorists tended to draw emphasis away from physical or contextual indicators of deprivation by stressing its psycho-social consequences (Bowlby 1951; Dennis 1953; Spitz 1945 & 1946). The impact of this shift is seen in later iterations of the RAD diagnostic criteria.

In the *DSM*-III (APA 1980) RAD diagnostic criteria applied only to infants under the age of eight months. In concert with the age criteria, a diagnosis was informed by failure-to-thrive, signs of age inappropriate social responsiveness, and apathy. A single criterion was included to address a lack of adequate caregiving (Spitzer and Cantwell 1980). This early description was criticized because it lacked precision and offered little insight into the underlying dynamics of the disorder (Achenbach 1980; Derivan 1982). Notwithstanding these concerns, the disorder became synonymous with "maternal deprivation," a concept largely drawn from attach-ment theory (Bowlby 1951 & 1958; Spitz 1945). RAD came to be equated as a "disorder of mothering" and was linked to poor mothering skills and maternal psychopathology (Derivan 1982; Evler 1982; Tibbits-Kleber and Howell 1985).

Critics of this earliest version of RAD also noted how selective attachments are only apparent in infants older than eight months (Rutter and Shaffer 1980). Others suggested a removal of failure-to-thrive as a diagnostic criteria (Richters and Volkmar 1994). Although critics generally agreed that the criteria needed revision, overall there was a consensus that RAD was a distinct disorder and one that could not be captured by other diagnostic categories in the *DSM* at that time (Volkmar 1997). The *DSM*-III-R (APA 1987) saw a re-conceptualization of the RAD criteria with age of onset revised from eight months to five years to accommodate attachment theory's understandings of the developmental trajectory of attachment formations. "Grossly inadequate" care was expanded to include care encompassing psychological concerns as well as physical abuse and neglect (APA 1987). Failure-to-thrive was dropped as an essential diagnostic feature. These revisions were largely replicated in the *DSM*-IV (APA 1994) and later in its text revision (*DSM*-IV-TR; APA 2000). Proposals for the *DSM*-V would see RAD split into two distinct disorders of infancy and childhood, the first to be labelled as Reactive Attachment Disorder, the second as Disinhibited Social Engagement Disorder (Zeanah and Gleason 2010).

At the moment, the *DSM*-IV-TR (APA 2000) defines the essential feature of RAD as "markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care" (127). Two distinct categories are articulated: the "Inhibited Type," characterized by the child's persistent failure to initiate and respond to most social interactions; and the "Disinhibited Type" distinguished by the child's indiscriminate sociability or inability to

select figures who are appropriate to serve attachment needs. Disturbances of both types must not be solely accounted for by developmental delays and should not meet criteria for any of the developmental disorders. Pathogenic care, a key requirement for diagnosing RAD, must underpin marked disturbances in the child's social relationships and attachment behaviours (APA 2000).

Problems with RAD as a Diagnostic Construct

Evidence shows us that infants and young children deprived of responsive caregiving are more likely to experience difficulties in forming healthy affectional bonds throughout their lifespan (Grossman et al. 2005; Stroufe 2005; Stroufe et al. 2005; Vaughn 2005). While deprivation is a serious social issue, it is not one effectively addressed by pathologizing those behaviours that occur as a result of the deprivation. Alongside broad social concerns surrounding the "disordering" of behaviours, there are a number of technical problems with the RAD diagnostic construct as currently defined. In 1997 Fred Volkmar noted that "[a]lthough empirical data on the reactive attachment disorder diagnostic concept, strictly defined, are rather limited, ample evidence supports its continued inclusion in the *DSM*-IV" (Volkmar 1997, 261). Thus far, only a handful of case studies have been published that assess the impact of severe deprivation on children as a consequence of institutionalization (Chisholm 1998; Iftene and Roberts 2004; O'Connor et al. 1999; O'Connor et al., 2003; O'Connor and Rutter 2000). Fewer studies report on the effects of maltreatment of noninstitutionalized children (Heller et al. 2006; Newman and Mares 2007; Skuse 1984a&b; Solomon and Peltz 2008). Also problematic are the lack of prevalence statistics. While the *DSM* notes that RAD "appears to be very uncommon" (APA 2000, 129), other sources exaggerate prevalence rates by conflating RAD with the as-yet un-authorized "attachment disorders," suggesting "over 1 million children in New York have attachment disorder symptoms" (Cain 2006, 1).

The way in which RAD criteria underwent revision is also problematic. Rather than acknowledging failure-to-thrive as a broad enough concept to accommodate the psycho-social symptoms associated with the disorder, it was dropped as a diagnostic criteria. Negative developmental outcomes for children raised in poverty and subjected to physical, sensory, nutritional, and emotional deprivations have been well documented (Ayoub et al. 2009; Richter 2004). Acknowledging the extent of deprivation as a consequence of poverty and abuse has in the past adequately accounted for children's psycho-social deficits, including those associated with forming and maintaining healthy relationships. Attachment theory's increasing popularity, in concert with a need to root mental illness in a psychiatric rather than medical or social discourses, are likely responsible for this unfortunate change in emphasis.

Other substantive concerns with the revisions made to the RAD criteria reflect the current lack of epidemiological and empirical evidence supporting the diagnosis. While two distinct forms of RAD are defined in the DSM-IV-TR, little evidence justified this division; some have questioned the approach, suggesting that infants and young children can exhibit symptoms of both the inhibited and disinhibited types of RAD, despite the fact that there is no provision in the *DSM* for making such a dual diagnosis (Newman and Mares 2007). Charles Zeanah and Anna Smyke's (2008) review of international adoption studies indicated how a substantial minority of adopted children display signs of indiscriminately social/disinhibited RAD persisting even after situations had been improved. By contrast, children who received an RAD diagnosis of emotionally withdrawn/inhibited tended to improve following placement in situations where the quality of care improved. These findings suggested to the authors that indiscriminate social behaviour may not, in fact, be a valid symptom representing RAD as currently defined (Zeanah and Smyke 2008). Given the issues noted above, RAD has been a demanding disorder to isolate and to diagnose accurately (Chaffin et al. 2008). It is one of the few disorders in the *DSM* requiring clinicians to evaluate both the child's physical and psycho-social environment as well as behavioural indicators of the disorder. While a child's symptoms may be assessed as meeting criteria for "indiscriminately social,"

without an evaluation of a pathogenic environment, an RAD diagnosis is precluded. Also problematic is the lack of standardized assessment tools available for diagnosis (Minde 2003). From a diagnostic perspective, other disorders of infancy and childhood share some of the same criteria with RAD and symptoms that should be used to define other disorders are sometimes confused as informing an RAD diagnosis (Newman and Mares 2007). Perhaps most problematic, while RAD is firmly entrenched in the *DSM*, to date there are no empirically tested or accepted treatments for the disorder (Chaffin et al. 2008).

In short, there are serious problems associated with RAD as a diagnostic construct, making its inclusion in the *DSM* questionable or, at the very least, premature. What we do have is the making of a "disorder" that can be used to describe and pathologize attachment behaviours of children who have been subjected to extremes of abuse and/or physical, sensory, nutritional, and emotional deprivation. With the proposed expansion into two distinct disorders, the problems are intensified.

Attachment Disorders

Although attachment styles of infancy, childhood, and adulthood are well established in the psychological and psychiatric literatures, they do not yet inform the *DSM* nosology for classifying mental disorders (Chaffin et al. 2008; Newman and Mares 2007). There is, however, an established trend in the literature suggesting RAD be subsumed under a general umbrella of "attachment disorders." In so doing, the "disorder" construct would be expanded to include attachment relationship anomalies as "disorders" (Pearce 2009; Prior and Glaser 2006). This expansion is proposed in spite of existing concerns about RAD as a diagnostic construct and the lack of evidence that would show clear associations between attachment classifications and specific psychiatric sequelae (Zeanah and Smyke 2008). At best, attachment styles might be considered as possible protective or risk factors for other "disorders." On their own, attachment classifications have limited predictive power and are without established links between specific patterns of attachment and specific disorders (Stroufe 2005).

Regardless of these concerns, efforts are ongoing to further pathologize relationship patterns that would see attachment security at the extreme positive end of an attachment disorder continuum, followed by insecure attachment, disorganized attachment, secure base distortions, and finally, disorders of non-attachment (i.e., RAD) at the extreme negative end of the continuum (Byrne 2003; O'Connor and Zeanah 2003a,b&c; Zeanah 1996; Zeanah and Boris 2000). Instruments have already been developed to evaluate "attachment disorders" (Boris et al. 2004), resulting in a surge of unstandardized tools (e.g., Minnis et al. 2002) some prematurely applied to suspected RAD cases. This has led to both mis- and overdiagnoses of the disorder (Green 2003; O'Connor et al. 2000). "Holding" therapies, advocated as treatment for ill-defined "attachment disorders" and by some for the treatment of RAD (e.g., Cain 2006), have resulted in some disastrous outcomes for children (e.g., death) (Chaffin et al. 2008; Steele 2003).

"Attachment disorders" are currently outside of the domain of the *DSM*. Given the flurry of activity in the extant literatures promoting the construct as well as understandings within the psychiatric and psychological communities of the important role attachment plays in informing psychopathology (Ross 2009), "attachment disorders" will likely find their way into the DSM in the not too distant future. Accepting "disordered" attachment as an individual deficit seems contrary to evidence suggesting how individuals use different attachment "styles" in different relationship contexts (Ross and Spinner 2001) as well as how "styles" can change over time in the same relationship (Baldwin and Fehr 1995). This would suggest that attachment styles can be conceptualized as flexible constructs that are open to change both within and between relationships. In order to fully under-stand "attachments," emphasis should be placed on the interactions between individuals and the contexts in which relationships develop and change. "Attachments" are far from immune to the same socioeconomic stressors that burden children's cognitive and emotional development.

Poverty and Mental Health

In a recent review of the literatures assessing the relationships between socio-economic status (SES) and psycho-social well-being, Jamie Pope and Nancy Arthur note, "[a]s one moves down the SES ladder, mortality and morbidity increase in almost every disease category, including psychological disorders" (2009, 56). In comparison to their economically advantaged peers, children from lower socio-economic groups "experience elevated levels of family conflict, diminished parental warmth, and less positive communication with caregivers" (57). Although SES is generally an understudied variable in counselling psychology (Bullock and Limbert 2009), in the attachment literature it has been identified as a risk factor (e.g., Cain 2006). Children raised in poverty are at higher risk for poor attachment outcomes and are more likely to be classified with insecure or disorganized attachment styles (Raikes and Thompson 2005). This is highlighted by the fact that teaching caregivers to be more sensitive to infant attachment needs by helping them to develop responsive parenting skills has been somewhat effective in treating RAD and other attachment problems (Cain 2006; Cairns 2008). As with other disorders noted in the *DSM*, the medicalization of attachment "de-politicizes the diagnosis and wipes away the troubling implications" (Marecek and Hare-Mustin 2009, 80) that overshadow social issues of poverty and intolerance to individual differences.

The *DSM* and the Making of Disorders

The DSM-IV-TR (APA 2000) conceptualizes mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (2000, xxxi). The syndrome or pattern cannot be "merely an expectable or culturally sanctioned response to a particular event" (2000, xxxi). Whatever the disorder's original cause, it must be considered "as a manifestation of a behavioral, psychological, or biological dysfunction in the individual" (xxxi). Jerome Wakefield (2005) notes how diagnostic criteria used to identify specific disorders in the *DSM* generally do not satisfy this definition. Pathogenic care, severe maltreatment, and deprivation can result in patterns of interpersonal behaviour dramatically different from those seen in children raised in less challenging circumstances. However, these different and less socially acceptable ways of relating could be framed more realistically as adaptive responses to intolerable social and economic conditions. Assessing a child's "indiscriminant sociability" or "marked inability to exhibit appropriate selective attachments" as adaptive responses would require both acknowledging the severe impact of poverty on child development as well as a revision to attitudes about what constitutes "normal" behaviour. If failing "to initiate or respond in a developmentally appropriate fashion to most social interactions" is a consequence of growing up in environments typified by "pathogenic care" in light of acts of violence and negligence, this failure would better be described as adaptive rather than "disordered." In short, RAD symptoms rely on negative social contexts. Societies that are tolerant of the conditions causing the "disorder" are intolerant of the resulting symptoms.

Conclusion

Many critics (Burstow 2005; Caplan 1995; Furedi 2004; Kirk and Kutchins 1992; Kutchins and Kirk 1997) have noted how the *DSM* purports to be a scientific inventory of psychiatric "disorders" but is in fact a "patchwork of scientific data, cultural values, political compromises, and material for making insurance claims" (Marecek and Hare-Mustin 2009, 78). The number of disorders appearing in the *DSM* has grown steadily from 198 categories in 1952 to 340 in 1994 (Marecek and Hare-Mustin 2009) and, with this growth, the *DSM* has played a dramatic role in expanding notions of pathology as well as public thinking about psychological matters (Martin 2006). The recent proposal to split RAD into two distinct disorders exemplifies this trend. With this expansion, society is led more and more towards adopting narrowing standards of what constitutes "normal" and

acceptable behaviour and what should be regarded as pathological and in need of psychiatric intervention (Malacek 2006). An RAD diagnosis demands pathological care as the precipitating factor for the disorder; pathological care is also implicated as underlying the more general descriptions of "attachment disorders." Poverty plays a major role in accounting for conditions that lead to pathological care. The time is long overdue to shift focus away from "disordering" behaviours and towards seeking the social and economic reforms that would change the contexts in which child-rearing and interpersonal relationships are doomed to pain and suffering.

Acknowledgments

A version of this paper was presented at the "Disorderly Conduct Conference," Wilfred Laurier University and University of Waterloo, Waterloo Ontario in July of 2009. I would like to thank conference organizers—Shannon Dea and Morgan Holmes—and all of the participants for discussions throughout the conference. I am grateful to the Women's Writing Group at the Augustana Faculty of the University of Alberta—Yvonne Becker, Kim Fordham, Roxanne Harde, Anne-Marie Link, Paula Marentette, Sandra Rein, Janet Wesselius—for discussions, suggestions, and support. And finally, I would like to thank the anonymous *Atlantis* reviewers for their thoughtful comments and insights.

References

Achenbach, T. "*DSM*-III in Light of Empirical Research on the Classification of Child Psychopathology," *Journal of the American Academy of Child Psychiatry.* 19.3 (1980): 395–412.

Ainsworth, M.D.S., M.C. Blehar, E. Waters, and S. Wall. *Patterns of Attachment: A Psychological Study of the Strange Situation*. New York: John Wiley & Sons, 1978.

Ainsworth, M. and B. Wittig. "Attachment and Exploratory Behaviour of One-Year Olds in a Strange Situation," *Determinants of Infant Behaviour* IV, B. Foss, ed. London: Methuen, 1969, pp. 113–36.

APA (American Psychiatric Association). *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition. Washington: APA, 1980.

———. *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition, revised. Washington: APA, 1987.

———. *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition. Washington: APA, 1994.

———. *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, revised. Washington: APA, 2000.

Ayoub, C., E. O'Connor, G. Rappolt-Schlictmann, G. Vallotton, H. Raikes, and R. Chazan-Cohen. "Cognitive Skill Performance Among Young Children Living in Poverty: Risk, Change, and the Promotive Effects of Early Head Start," *Early Childhood Research Quarterly.* 24 (2009): 289–305.

Bakwin, H. "Emotional Deprivation in Infants," *Journal of Pediatrics.* 35 (1949): 512–21.

Baldwin, M.W., and B. Fehr. "On the Instability of Attachment Style Ratings," *Personal Relationships.* 2 (1995): 247–61.

Boris, N., S. Hinshaw-Fuselier, A. Smyke, M. Scheeringa, S. Heller, and C. Zeanah. "Comparing Criteria for Attachment Disorders: Establishing Reliability and Validity in High-Risk Samples," *Journal of the American Academy of Child and Adolescent Psychiatry.* 43.5 (2004): 568–77.

Bowlby, J. "Forty-Four Juvenile Thieves: Their Characters and Home Life," *International Journal of Psychoanalysis.* 25 (1944): 1–57 & 207–28.

———. "Maternal Care and Mental Health," *Bulletin of the World Health Organization.* 3 (1951): 355–534.

———. "The Nature of the Child's Tie to the Mother," *International Journal of Psychoanalysis.* 39 (1958): 350–69.

———. *Attachment and Loss: Vol. 1., Attachment*. New York: Basic Books, 1969.

———. *Attachment and Loss: Vol. 2., Separation: Anxiety and Anger*. New York: Basic Books, 1973.

———. "The Making and Breaking of Affectional Bonds," *British Journal of Psychiatry.* 130 (1977): 201–10.

———. *Attachment and Loss: Vol. 3., Loss, Sadness and Depression*. New York: Basic Books, 1980.

Bullock, H. and W. Limbert. "Class," *Critical Psychology: An Introduction*, 2nd edition, D. Fox, I. Prilleltensky and S. Austin, eds. London: SAGE, 2009, pp. 215–31.

Burstow, B. "A Critique of Posttraumatic Stress Disorder and the *DSM*," *Journal of Humanistic Psychology*. 45.4 (2005): 429–55.

Byrne, J. "Referral Biases and Diagnostic Dilemmas," *Attachment & Human Development*. 5.3 (2003): 249–52.

Cain, C. *Attachment Disorders: Treatment Strategies for Traumatized Children*. Lanham, Maryland: Jason Aronson Publishing, 2006.

Cairns, K. *Attachment, Trauma and Resilience: Therapeutic Caring for Children*. London: British Association for Adoption & Fostering, 2008.

Caplan, P. *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*. Reading, MA: Addison-Wesley Publishing Company, 1995.

Chaffin, M., R. Hanson, B. Saunders, T. Nichols, D. Barnett, C. Zeanah, L. Berliner, B. Egeland, E. Newman, T. Lyon, E. LeTourneau, and C. Miller-Perrin. "Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems," *Child Maltreatment*. 11.1 (2008): 76–89.

Chisholm, K. "A Three Year Follow-up of Attachment and Indiscriminate Friendliness in Children Adopted from Romanian Orphanages," *Child Development*. 69 (1998): 1092–106.

Dennis, W. *Children of the Creche*. New York: Appleton-Century-Crofts, 1953.

Derivan, A. "Disorders of Bonding in Failure to Thrive," *Failure to Thrive in Infancy and Early Childhood*, P. Accardo, ed. Baltimore: University Park, 1982, pp. 91–103.

Evler, G. "Nonmedical Management of the Failure-to-thrive Child in a Pediatric Inpatient Setting," *Failure to Thrive in Infancy and Early Childhood*, P. Accardo, ed. Baltimore: University Park, 1982, pp. 243–63.

Furedi, F. *Therapy Culture: Cultivating Vulnerability in an Uncertain Age*. London: Routledge, 2004.

Green, J. "Are Attachment Disorders Best Seen as Social Impairment Syndromes?" *Attachment & Human Development.* 5.3 (2003): 259–64.

——— and R. Goldwyn. "Annotation: Attachment Disorganization and Psychopathology: New Findings in Attachment Research and Their Potential Implications for Developmental Psychopathology in Childhood," *Journal of Child Psychology and Psychiatry*. 43.7 (2002): 835–46.

Grossmann, K. E., K. Grossmann and E. Waters, eds. *Attachment from Infancy to Adulthood: The Major Longitudinal Studies*. New York: The Guilford Press, 2005.

Harris, J. "Nonorganic Failure-to-Thrive Syndromes: Reactive Attachment Disorder of Infancy and Psychosocial Dwarfism of Childhood," *Failure to Thrive in Infancy and Early Childhood*, P. Accardo, ed. Baltimore: University Park Press, 1982, pp. 229–41.

Heller, S., N. Boris, S. Fuselier, T. Page, N. Koren-Karie and D. Miron. "Reactive Attachment Disorder in Maltreated Twins Follow-up: From 18 Months to 8 Years," *Attachment & Human Development.* 8.1 (2006): 63–86.

Iftene, F. and N. Roberts. "Romanian Adolescents: Literature Review and Psychiatric Presentation of Romanian Adolescents Adopted in Romania and in Canada," *The Canadian Child and Adolescent Psychiatry Review.* 13.4 (2004): 110–13.

Kirk, S. and H. Kutchins. *The Selling of the DSM: the Rhetoric of Science in Psychiatry*. New York: Aldine de Gruyter, 1992.

Kutchins, H. and S. Kirk. *Making Us Crazy. DSM: The Psychiatric Bible and the Creation of Mental Disorders*. New York: The Free Press, 1997.

Main, M. and E. Hesse. "Parents' Unresolved Traumatic Experiences Are Related to Infant Disorganized Status: Is Frightened And/or Frightening Parental Behaviour the Linking Mechanism?" *Attachment in the Preschool Years*, M. Greenberg, D. Cicchetti and E. Cummings, eds. Chicago: University of Chicago Press, 1990, pp. 161–84.

Main, M. and J. Solomon. "Discovery of an Insecure-Disorganized/Disoriented Attachment Pattern," *Affective Development in Infancy*, T. Brazelton and M. Yogman, eds. Norwood, NJ: Ablex, 1986, pp. 95–124.

Malacek, S. "Biopsychiatry and the Permanent War Economy," *Journal of Critical Psychology, Counselling and Psychotherapy*. 6.2 (2006): 88–93.

Marecek, J. and R. Hare-Mustin. "Clinical Psychology: The Politics of Madness," *Critical Psychology: An Introduction*, 2nd edition, D. Fox, I. Prilleltensky and S. Austin, eds. London: SAGE, 2009, pp. 75 – 92.

Martin, M. *From Morality to Mental Health: Virtue and Vice in a Therapeutic Culture*. Oxford: Oxford University Press, 2006.

Minde, K. "Assessment and Treatment of Attachment Disorders," *Current Opinion in Psychiatry*. 16, 2003, pp. 377–81.

Minnis, H., S. Rabe-Hesketh, and S. Wolkind. "Development of a Brief, Clinically Relevant Scale for Measuring Attachment Disorders," *International Journal of Methods in Psychiatric Research*. 11.2 (2002): 90–98.

Newman, L. and S. Mares. "Recent Advances in the Theories of and Interventions with Attachment Disorders," *Current Opinion in Psychiatry*. 20 (2007): 343–48.

O'Connor, T., D. Bredenkamp, M. Rutter, and the English and Romanian Adoptees (ERA) Study Team. "Attachment Disturbances and Disorders in Children Exposed to Early Severe Deprivation," *Infant Mental Health Journal*. 20.1 (1999): 10–29.

O'Connor, T., R. Marvin, M. Rutter, J. Olrick, P. Britner, and the English and Romanian Adoptees (ERA) Study Team. "Child-parent Attachment Following Early Institutional Deprivation," *Developmental Psychopathology*. 15 (2003): 19–38.

O'Connor, T. and M. Rutter. "Attachment Disorder Behavior Following Early Severe Deprivation: Extension and Longitudinal Follow-up," *Journal of the American Academy of Child and Adolescent Psychiatry*. 39 (2000): 703–12.

O'Connor, T., M. Rutter, C. Beckett, L. Keaveney, J. Kreppner, and the English and Romanian Adoptees (ERA) Study Team. "The Effects of Global Severe Privation on Cognitive Competence: Extension and Longitudinal Follow-up," *Child Development.* 71 (2000): 376–90.

O'Connor, T. and C. Zeanah. "Introduction to the Special Issue: Current Perspectives on Assessment and Treatment of Attachment Disorders," Attachment & Human Development. 5.3 (2003a), 221–22.

———. "Attachment Disorders: Assessment Strategies and Treatment Approach," *Attachment & Human Development.* 5.3 (2003b): 223–44.

———. "Current Perspectives on Attachment Disorders: Rejoinder and Synthesis," *Attachment & Human Development.* 5.3 (2003c): 321–26.

Olsen, E. “Failure to Thrive: Still a Problem of Definition,” *Clinical Pediatrics*. (Jan./Feb. 2006): 1–6.

Pearce, C. *A Short Introduction to Attachment and Attachment Disorder*. London: Jessica Kingsley Publishers, 2009.

Prior, V. and D. Glaser. *Understanding Attachment and Attachment Disorders: Theory, Evidence and Practice.* London: Jessica Kingsley Publishers, 2006.

Pope, J. and N. Arthur. “Socioeconomic Status and Class: A Challenge for the Practice of Psychology in Canada,” *Canadian Psychology*. 50.2 (2009): 55–65.

Provence, S. and R. Lipton. *Infants in Institutions.* New York: International Universities Press, 1962.

Raikes, H. and R. Thompson. “Links Between Risk and Attachment Security: Models of Influence*,” Applied Developmental Psychology*. 26.4 (2005): 440–55.

Richter, L. “Poverty, Underdevelopment, and Infant Mental Health,” *Infant Mental Health Journal*. 25.5 (2004): 440–52.

Richters, M. and F. Volkmar. “Reactive Attachment Disorder in Infancy or Early Childhood,” *Journal of the American Academy of Child and Adolescent Psychiatry*. 33.3 (1994): 328–32.

Ross, L.R. “Attachment Theory: Assimilation into the Clinical Practice of Psychologists and Psychiatrists in Canada.” Unpublished manuscript, 2009.

——— and B. Spinner. “General and Specific Attachment Representations in Adulthood: Is There a Relationship?” *Journal of Social and Personal Relationships*. 18 (2001): 747–67.

Rutter, M. *Maternal Deprivation Reassessed*. New York: Penguin Books, 1972.

——— and D. Shaffer. “*DSM*-III: A Step Forward or Back in Terms of the Classification of Child Psychiatric Disorders?” *Journal of the American Academy of Child Psychiatry.* 19.3 (1980): 371–94.

Schwartz, I.D. “Failure to Thrive: An Old Nemesis in the New Millennium,” *Pediatrics in Review*. 21.8 (2008): 257–64.

Skeels, H. and H. Dye. “A Study of the Effects of Differential Stimulation of Mentally Retarded Children,” *Proceedings of the American Association of Mental Deficiency.* 44 (1939): 114–36.

Skuse, D. “Extreme Deprivation in Early Childhood - I. Diverse Outcomes for Three Siblings from an Extraordinary Family,” *Journal of Child Psychology and Psychiatry*. 25.4 (1984a): 523–41.

———. “Extreme Deprivation in Early Childhood - II. Theoretical Issues and a Comparative Review,” *Journal of Child Psychology and Psychiatry*. 25.4 (1984b): 543–72.

Smail, D. “Psychology and Power: Understanding Human Action,” *Journal of Critical Psychology, Counselling and Psychotherapy*. 8.3 (2008): 130–39.

Solomon, L. and L. Peltz. “Clinical Case Rounds in Child and Adolescent Psychiatry: Separation, Autism, and Residential Treatment,” *Journal of the Canadian Academy of Child and Adolescent Psychiatry*. 17.1 (2008): 26–28.

Spitz, R. “Hospitalism: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood,” *Psychoanalytic Study of the Child*. 1 (1945): 53–74.

———. “Anaclitic Depression: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood,” *Psychoanalytic Study of the Child. 2* (1946): 313–42.

Spitzer, R. and D. Cantwell. “The *DSM*-III Classification of Psychiatric Disorders of Infancy, Childhood, and Adolescence,” *Journal of the American Academy of Child Psychiatry*. 19.3 (1980): 356–70.

Steele, H. “Holding Therapy Is Not Attachment Therapy: Editor's Introduction to this Invited Special Issue,” *Attachment & Human Development*. 5.3 (2003): 219.

Stroufe, A. “Attachment and Development: A Prospective, Longitudinal Study from Birth to Adulthood,” *Attachment & Human Development*. 7.4 (2005): 349–67.

———, B. Egeland, E. Carlson, and W. Collins. *The Development of the Person: The Minnesota Study of Risk and Adaptation from Birth to Adulthood*. New York: The Guilford Press, 2005.

Tibbits-Kleber, A. and R. Howell. “Reactive Attachment Disorder of Infancy (RAD),” *Journal of Clinical Child Psychology*. 14.4 (1985): 304–10.

Tizard, B. and J. Hodges. “The Effects of Early Institutional Rearing on the Development of Eight Year Old Children,” *Journal of Child Psychology and Psychiatry.* 19 (1978): 99–118.

——— and J. Rees. “The Effect of Early Institutional Rearing on the Behaviour Problems and Affectional Relationships of Four Year Old Children,” *Journal of Child Psychology and Psychiatry*. 16 (1975): 61–73.

Vaughn, B. “Discovering Pattern in Developing Lives: Reflections on the Minnesota Study of Risk and Adaptation from Birth to Adulthood,” *Attachment & Human Development*. 7.4 (2005): 369–80.

Volkmar, F. “Reactive Attachment Disorder,” *DSM-IV Sourcebook Volume 3*, T. Widiger et al., eds. Washington DC: American Psychiatric Association, 1997, pp. 255–78.

Wakefield, J. “Disorders Versus Problems of Living in the *DSM*: Rethinking Social Work’s Relationship to Psychiatry,” *Mental Disorders in the Social Environment: Critical Perspectives,* S. Kirk, ed. New York: Columbia University Press, 2005, pp. 93–95.

Zeanah, C. “Beyond Insecurity: A Reconceptualization of Attachment Disorders of Infancy,*” Journal of Consulting and Clinical Psychology*. 64.1 (1996): 42–52.

——— and N. Boris. “Disturbances and Disorders of Attachment in Early Childhood,” *Handbook of Infant Mental Health*, 2nd edition, C. Zeanah, ed. New York: Guilford, 2000, pp. 353–68.

——— and M. Gleason. *Reactive Attachment Disorder: A Review for DSM-V*. <www.*DSM*5.org/Proposed%20Revision%20Attachments/APA%20*DSM*-5%20Reactive%20Attachment%20Disorder%20Review.pdf>

Zeanah, C. and A. Smyke. “Attachment Disorders in Family and Social Context,” *Infant Mental Health Journal.* (2008).