

Referral biases and diagnostic dilemmas

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O'Connor & Zeanah's target article provides a sound exposition of the current state of knowledge of attachment disorders. It sets out what is known but, perhaps more importantly, highlights what the key limitations of our knowledge are and what kinds of clinical research strategies are needed to move the field on. Taking the target article as a starting point, this response aims to identify some of the concerns about referral bias observed in clinical practice and discuss the implications of mis-diagnosis in routine Child and Adolescent Mental Health Services (CAMHS). These points are illustrated with brief reference to a clinical case.

There is growing suspicion that children with attachment disorders are seldom referred to CAMHS because of the attachment disorder behaviour *per se*; rather, children who, upon close examination, show some features of possible attachment disorder are most often referred because of co-occurring difficulties, notably disturbances in attention and concentration, stealing, aggressive behaviour, or marked problems in peer and family relationships. Why it is that specific behaviours or symptoms listed in the Reactive Attachment Disorder (RAD) category are unlikely to prompt parents to seek referral deserves some attention. On the other hand, parents who have adopted or fostered children and who have been exposed to the popular notions of Reactive Attachment Disorder (e.g., via the internet) show no such reticence to seek out mental health attention. Curiously, however, the 'referral bias' in the latter instance is the opposite of that previously mentioned: these children are swiftly referred for clinical attention because even the more conventional kinds of clinical problems are thought to index an attachment disorder when, in fact, they probably do not (e.g., conduct problems are construed as part of the RAD syndrome).

Regardless of why a child with attachment disorder related symptoms may have been referred to a clinic, the absence of a standard assessment protocol or even general clinical assessment guidelines will no doubt lead to substantial variation among clinicians in how to assess and make sense of attachment disorder symptoms. Moreover, a lack of assessment guidelines increases the possibility that such symptoms will go undetected. Clinical experience suggests that this may occur with some regularity. We can therefore draw two lessons for future clinical research. First, we should be very attentive to the way in which samples are ascertained. Referral biases in this area are complex and may lead to under- and mis-reporting of attachment disorders. Second, as O'Connor & Zeanah emphasize, there is a great need to distinguish between core symptoms of RAD and the many co-occurring problems often found in children with (suspected) attachment disorder.

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A further assessment and diagnostic task for the clinician that was highlighted by O'Connor & Zeanah is to distinguish between Insecure/Disorganized attachment (i.e., the child does have a selective attachment, but one that is insecure) and attachment disorder (i.e., the child has not formed a selective attachment). However, although conceptually important, this distinction is often very difficult to make in clinical practice. Thus, there are no existing measures to identify whether or not the child shows a selective or discriminating attachment to his/her caregiver(s) – despite the existence of several measures to distinguish secure and insecure selective attachment relationships. Furthermore, the assessment of whether or not the child shows a selective attachment may be confounded by the child's changing caregiving relationships. For example, consider the case of a child who was severely abused and then removed into care. The expectation is that this child would have developed a selective but Disorganized attachment with the biological parent. Yet, this is the kind of child who might be suspected of exhibiting attachment disorder behaviour once placed in the foster home. Did this child show RAD behaviour toward the biological parent prior to removal, alongside the Disorganized behaviour? That possibility is at least implied by the fact that criteria for the inhibited form of RAD have several parallels with behaviours 'diagnostic' of Disorganized behaviour – although in the absence of necessary data that may be more an hypothesis or merely a coincidence. Alternatively, did the RAD behaviour emerge only after placement into a new home? Furthermore, does it dissipate over time with adequate care? Clinical experience suggests that there have been at least some cases in which the attachment disorder behaviour in the foster home appeared *de novo*, despite strong retrospective evidence that the child had developed a selective attachment to the biological parents (albeit an insecure one) prior to removal. In short, we know little about the RAD behaviour of children prior to placement in the adoptive/foster home.

CLINICAL CASE EXAMPLE

The case chosen was purposefully not a 'typical' RAD case, but instead a child whose history and current symptom pattern is merely suggestive of RAD. This case therefore exposes the thornier diagnostic and assessment dilemmas, and may be more representative of the kinds of clinical questions that might confront professionals working within the CAMHS setting.

At 2 weeks of age, Case B was removed from his biological mother and placed with foster parents, with whom he stayed until 2 months; at 2 months, he was returned to his biological mother. However, just 10 weeks after this move, B was removed again from his biological mother and returned to his foster – eventually adoptive – parents. While in the care of his mother during the second session (from about 2 months until almost 5 months of age), B experienced deprivation severe enough to require hospitalization for dehydration and pressure sores.

When B was returned to the adoptive parents at 5 months, he was reported to show attachment behaviours toward them. In his first year, B showed normal eye contact and was described as a cuddly baby. Onset of stranger anxiety was age-appropriate, although he did show particular anxiety toward women with dark hair (his biological mother but not his adoptive mother had dark hair). B displayed some tendency for ritual/obsessive behaviour beyond what would be considered normal in pre-school and early school years (e.g., B would become very upset if other children in the crèche

changed seats). In addition, he was obsessed with food, hoarded food, and ate indiscriminately both with respect to what he ate and how much. Reliable information on whether or not B showed RAD symptoms in early childhood was not available.

B's parents first expressed concern about him when he was approximately 7-years-old because of his poor attention and concentration and disorganization. He was also clumsy and had poor coordination. B was also being bullied at school and had no friends. At that time, B was diagnosed with Attention Deficit Disorder.

B first came to my attention when he was 14 years. He was referred to a Child Psychiatric Clinic because of stealing compulsively and lying. For instance, he would steal mobile phones, but neither sell them nor realize their value in any way (he had quite a stockpile). Clinical assessment and developmental tests indicated that he met diagnostic criteria for Social Phobia and Attention Deficit Hyperactivity Disorder. Testing also indicated that he had a normal IQ, with the exception of non-verbal intellectual abilities (which were between low average) and mild learning difficulties. No difficulties with semantic or pragmatic use of language were detected. His responses to a clinical attachment interview were remarkably impoverished, suggesting a poorly formed attachment representation. Specifically, he was unable to describe his relationships with his parents beyond the most cursory descriptions; this was congruent with parental perceptions that B did not demonstrate an unambiguous attachment toward them. B also had great difficulty participating in a Social Skills group programme; he tended to mimic other children's responses, much to their irritation. Nevertheless, he showed some capacity for empathy and could anticipate and respond to other children's and staff members' emotion. He could also understand and use humour. Clinically, B was a likeable boy who had some insight into the social problems he was having and was motivated to have and maintain friends. In brief, B showed a complex mix of symptoms, ranging from the social problems sometimes associated with Asperger's syndrome, conduct symptoms, and relationship problems with parents and a history of disrupted and neglectful care that might signal attachment disorder. However, he fulfilled none of these diagnoses and, more to the point, each of these core symptoms contrasted with the way they are ordinarily observed (e.g., his stealing behaviour was much more like hoarding than stealing). Treatment recommendations were equally puzzling and unclear.

The cases raise a number of important clinical and conceptual questions. Clinically, the case underscores the need for a more fine-tuned assessment of the children's language and cognitive abilities, especially social-cognitive processes and mentalizing, or understanding of the thoughts and feelings of self and other. These features, which were especially evident in the interview with the child about his social and attachment relationships, may be of special importance when assessing attachment disorders in older children and adolescents. Secondly, although the kinds of problems that needing changing were clear, he did not easily fit the profile of a child who would likely benefit from most available treatment approaches. Deficits in social skills were perhaps most striking, but there was not encouraging progress from a social skills group.

Conventional wisdom (e.g., from the American Psychiatric Association) proposes that attachment disorder is a rare phenomenon. Yet, there is a growing impression among clinicians in CAMHS that attachment disorder-like or attachment disorder-related behavioural problems are not infrequent; experiences within the child forensic context are even more populated by these concerns. This impression needs to be

substantiated, and the development of clinically informative assessment tools is an essential step toward that goal.

There is now an exciting synthesis between clinical work and attachment research and theory. Yet, at the same time, there is a striking disconnect between the particular attachment problems shown by children who experience early caregiving deprivation and the types of intervention suggested for these children (which are unsupported and potentially harmful). Bridging this gap stands out as a key clinical task for future work.