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Forty-four juvenile thieves revisited: from bowlby to reactive attachment disorder

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Abstract

Background John Bowlby's work on attachment has had a major influence on practice in child and adolescent psychiatry and developed from observations Bowlby made in his clinical work. In a published case series of work with juvenile offenders, he provided a case description of the differing sets of problems that drove his interest. Clinical features described in a subgroup of these offenders, the 'affectionless psychopaths', might be recognized now as reactive attachment disorder (RAD).

Methods We scrutinized Bowlby's case series '44 Juvenile Thieves' and compared the aetiology and clinical features of a subgroup of these children with the other 74 cases described by Bowlby. We selected one typical case as an exemplar and provide an edited version here. We then present one composite case from a recent study of RAD and provide a comparison with typically developing children.

Results Of the Bowlby cases, 86% had experienced early prolonged separation from their primary caregivers and had experienced multiple care placements. In total, 10% of clinical comparisons had been similarly separated. In our recent sample, 66% of children experienced separation from primary caregivers compared with none of the comparison group. A similar proportion of our sample of children with RAD had been removed from home as a result of neglect or had experienced other forms of maltreatment.

Conclusions Bowlby beleived that a main aetiological factor in the development of difficulties was the experience of separation. We suspect that a main aetiological factor in both his and our cases is the experience of maltreatment. We suggest that RAD arises from a complex interplay of genetic and environmental triggers.

Keywords
attachment theory, case study, child psychiatry, reactive attachment disorder

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Introduction

John Bowlby is well known as the father of attachment theory, expounded in his landmark trilogy, Attachment (Bowlby 1973a), Separation (Bowlby 1973b) and Loss (Bowlby 1980). Bowlby described how young infants, across species, seek proximity with primary caregivers. These primary carer relationships are formed in the very first months of an infants life with the evolutionary biological function of maintaining the infants survival through feeding, nurturing and keeping the infant safe from harm (Holmes 1993). What is less well recognized about Bowlby, however, is that his interest in early parent–infant interaction stemmed from his clinical work with young offenders and that his theory of attachment developed from his formulations relating to this work.

The 1930s and 1940s was a time of intense interest in the effects of maltreatment and institutionalization. Various authors described maltreated children with a perplexing mixture of a failure to develop or maintain genuine family relationships while being sociable or overfriendly with strangers (Levy 1937; Lowrey 1940). In 1944 Bowlby published a case series of 44 children referred to the London Child Guidance Clinic for stealing, plus 44 clinic control children who were 'unstable or neurotic' but had not been referred for stealing (Bowlby 1944). At this time, there was no accepted nosology for describing these children's difficulties and Bowlby attempted to classify them according to certain core characteristics. He was particularly interested in a subgroup of 14 young offenders, three girls and 11 boys, whom he described as 'affectionless psychopaths' with a similar constellation of difficulties to those noted by Levy and Lowrey (Levy 1937; Lowrey 1940). By analysing these cases with knowledge from the present day, we suspect that he was describing a group of children who may now be diagnosed with reactive attachment disorder (RAD) (World Health Organisation 1993).

Bowlby developed attachment theory from his observations of children's response to the breaking of bonds with their primary care giver (in his era primarily mothers). In particular, he was struck by the level of distress that children showed around this separation. Bowlby felt that theories from psychoanalysis did not explain this level of distress. He postulated that the bond between mother and child (or attachment) was in itself a psychological process of great meaning (Holmes 1993). This theory of attachment is defined by Holmes as

> . . . a spatial theory, when I am close to my loved one I feel good, when I am far away I am anxious, sad or lonely.

Attachment theory is an overarching term for the three interrelated concepts which distinguish it (Holmes 1993). Attachment is the quality of the attachment relationship which a child or other individual is able to form and can be grouped as either secure or insecure. Attachment behaviour is the type of behaviour that is exhibited when an attachment relationship is disrupted by separation or indeed where separation is threatened. Behaviours exhibited will be normally assuaged by the re-establishment of proximity with the primary carer. The Attachment behavioural system is the model or blueprint with which a child or individual sees the world and which drives the interpersonal attachment relationships they make. These systems have been further categorized for clinical and research purposes (Table 1).

Table 1. Patterns of attachment in Strange situation procedure (Ainsworth 1979)

Attachment pattern	Description
Secure attachment (B)	Infants are usually (but not always) distressed by separation. On reunion they greet parent, receive comfort if required and can return to play.
Insecure-avoidant (A)	Children show few overt signs of distress on separation, and ignore parents on reunion.
Insecure-ambivalent (C)	Children are highly distressed by separation and cannot be easily pacified on reunion. They might seek contact but then resist by kicking out or turning away. They might continue to alternate between anger and clinging for some time.
Insecure-disorganized (D)	Show a diverse range of confused behaviours including freezing, or stereotyped behaviours when reunited with parents.

Reactive attachment disorder is a psychiatric disorder of childhood which has been included in the Diagnostic and Statistical Manual (DSM) and International Classification of Diseases (ICD) since the early 1990s (American Psychiatric Association 1994; World Health Organisation 1993). The symptom profile developed through the publication of case reports or studies of children who had been institutionalized (Spitz 1945; Goldfarb 1945; Tizard & Hodges 1978; Richters & Volkmar 1994). In each of the classification manuals, there is a necessity for diagnosis of RAD that children have a disturbance in their capacity to develop appropriate social relationships. This difficulty should be a consequence, in most cases, of parental neglect, pathogenic care or serious mishandling in the early years. In all cases, the onset of these difficulties should be evident before the age of 5 years and the difficulties should be persistent but amenable to change if the child is subsequently cared for in a supportive environment.

While the classification manuals differ somewhat in the amount of symptoms they include and how these are divided, there are a number of core common symptoms in both (Table 2). Inhibited RAD (categorized as reactive attachment disorder in ICD10) shares the symptoms of excessive inhibition, fearfulness or hyper-vigilance in social relationships along with ambivalent or contradictory responses. ICD10 also lists a number of other symptoms including peer problems, aggression, misery and failure to grow. Disinhibited RAD (categorized as disinhibited attachment disorder in ICD10) shares the symptoms of diffuse attachments and excessive familiarity with strangers. ICD10 includes peer problems and association with other emotional or behavioural disturbances in the symptom profile. Clinical expertise, research and understanding of this disorder has begun to progress slowly, but professional and public awareness remain limited and there is a consensus that

Table 2. A summary of and comparison between the two diagnostic classifications of RAD

DSM IV		ICD10
Key feature	Disturbance of social relatedness in most contexts associated with grossly pathogenic care	Abnormalities in social relationships associated with severe parental neglect, abuse or serious mishandling
Course	Onset in first 5 years. Persistent but remission is possible in appropriately supportive environment	Onset in first 5 years. Persistent but reactive to changes in environmental circumstances.
Inhibited form		*RAD*
Excessively inhibited or hypervigilant social interactions		Fearfulness and hypervigilance which do not respond to comforting
Ambivalent or contradictory responses		Contradictory or ambivalent social responses particularly at partings and reunions
No Equivalent		Poor social interaction with peers; aggression towards self and others; misery or apathy; growth failure in some cases
Disinhibited form		*Disinhibited attachment disorder*
Diffuse attachments		Diffuse non-selectively focused attachments in early childhood
Excessive Familiarity with strangers		Attention seeking and indiscriminate friendliness in middle childhood
No Equivalent		Poorly modulated peer interactions; may be associated emotional or behavioural disturbances

DSM, Diagnostic and Statistical Manual; ICD, International Classification of Diseases; RAD, reactive attachment disorder.

the diagnostic criteria for attachment disorder provide an inadequate clinical picture (O'Connor & Zeanah 2003). Recent research has demonstrated that mixed (Inhibited and Disinhibited) patterns are common in clinical samples (Boris *et al*. 2004; Minnis *et al*. 2009).

We aim to demonstrate how John Bowlby used the case series methodology to describe and begin to understand the mechanisms of what we would now call RAD. We will then use our own data to demonstrate some more recently recognized aspects of the disorder which may help us to understand the mechanisms of RAD. Finally, we discuss the relationship between RAD and attachment theory.

Methods

Design

We scrutinized John Bowlby's case series '44 Juvenile Thieves', which describes 44 'thieves' and 44 'non-theiving controls' (Bowlby 1944) and made a statistical comparison between the 14 cases described by Bowlby as 'affectionless psychopaths' with the other 74 cases who acted, for the purposes of the analysis, as a clinical control group. We compared the two groups on the two potential aetiolgical factors of interest, namely, experience of maltreatment and experience of separation using chi-squared tests or Fisher's Exact Test where criteria for chi-squared tests were not fulfilled. We selected a typical case as an exemplar. We then present a composite case from a recent study of RAD and provide a similar comparison with children not diagnosed with RAD (Minnis *et al*. 2009).

Bowlby's assessment process

The '44 Juvenile Thieves' paper describes 88 children, aged 5–16 years, who were assessed and/or treated at the London Child Guidance Clinic between 1936 and 1939 [demographics described in Part II of Bowlby's case series (Bowlby 1944, pp. 107–124)]. A full-scale IQ, observations of the child's emotional state and a full family and social history were performed.

Assessment of the current sample

The Reactive Attachment Disorder Assessment Research (RADAR) study aimed to develop a gold standard assessment tool for RAD. A total of 77 children and primary caregivers were recruited to participate in the RADAR study. In total, 38 of these were recruited through specialist child psychiatry clinics or from specialist social workers and were thought to likely to be

Table 3. Reactive attachment disorder (RAD) assessment research assessment measures*

Measures for assessing RAD symptoms	Parental semi-structured interview on RAD Child Adolescent Psychiatric Assessment (CAPA interview Style – Angold & Costello 2000) Waiting Room Observation (WRO) (Minnis *et al.* 2009) Parent and Teacher Relationship Problems Questionnaire (RPQ) (Minnis *et al.* 2002)
Measure of attachment	The Manchester Child Attachment Story Task (MCAST) (Green & Goldwyn 2002)
Measures of other psychiatric disorders	Semi-structured parental interview – Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder CAPA modules (Angold & Costello 2000) The strength and difficulties questionnaire, parent and teacher versions (SDQ) (Goodman *et al.* 2003) Structured parent interview for autism spectrum disorder – The Developmental, Dimensional and Diagnostic Interview (3di) (Skuse *et al.* 2004)
Measures of verbal IQ	The British Vocabulary Picture Scale (BPVS) (Atkinson 1992)
Demographic information	personal and family details and Life events CAPA modules (Angold & Costello 2000)

*A full description of methods and measures can be read in the supporting materials of Minnis and colleagues (2009) available at http://www3.interscience.wiley.com/journal/122296506/suppinfo

suffering from RAD. In all, 39 comparison children were recruited from a community general practice and highly unlikely to be suffering from RAD. Verbal IQ and structured psychiatric assessment (using structured observations, standardized questionnaires, semi-structured interviews and measures of attachment) were performed (see Table 3).

For ethical reasons, the RADAR case presented here has been constructed from the merged details of three of the cases who participated in the research. Gender of children, parents and carers and details of life events have been modified to protect anonymity, quotes were taken from transcripts of interviews with other cases and the reported verbal IQ gives an indication of what was usual for cases presenting in the study.

Local and national ethical approval was granted for assessment of the families involved in the RADAR study and cases were checked for anonymity by the research sponsor.

Results

Of Bowlby's 14 'affectionless psychopaths', 12 (86%) had experienced early and prolonged separation from their main attachment figure compared with seven (9.4%) of the comparisons (the 74 other clinic children) ($\chi^2 = 40.8$; $P < 0.001$). All of the 'affectionless' children who experienced separation also experienced either multiple moves or other adverse circumstances during separation (such as not being visited by parents during hospitalization). In our own sample of children with RAD, 25 (65.7%) had experienced separation from parents compared with none of the typically developing comparison group ($\chi^2 = 32.9$; $P < 0.001$). In all, 22 (60%) of the children diagnosed as having RAD had been removed from home because of neglect compared with none of the comparison group, 23 (70%) of children in the RAD group had been physically and/or sexually abused while 12 (30%) had at least one risk factor for early relationship difficulties (e.g. parental drug misuse or parental mental illness) (Fisher's exact test $P < 0.001$ for all indices). In our RAD sample, one-third (12) were currently living in family foster care or residential care, eight (22%) in kinship placements, 13 (36%) with birth families and three (8%) with adoptive families. All comparison children were living with birth parents, none had experienced adverse life events and none were in contact with child and adolescent mental health services (for more details of the RADAR sample, see Minnis *et al.* 2009).

Bowlby case example (Bowlby 1944, pp. 38–50)

Betty

Betty, aged 5 years, was referred by the school because of persistent stealing of pennies. She was the eldest of four children and was described as 'difficult from birth', 'always crying and screaming'. When Betty was 7 months old, her mother, while again pregnant, discovered that her husband was married to someone else. Betty was placed in a series of foster homes and was finally placed in a convent school for a year. 'In all of [the placements] she was unmanageable and was said to have been harshly treated'. At age 5 years, her mother insisted on having her home, but her mother described how 'she looks like a child who has just come in to play and does not seem to belong'.

Personality

Betty was described as 'undemonstrative' by her mother, but she was also highly sensitive to criticism and cried easily. At school, she was said to be 'deliberately disobedient and provoking' but when punished she 'became wooden'.

Examination at the clinic

> She struck everyone as a particularly attractive and delightful child. She had a most engaging smile, a twinkle in her eye, and an elf-like way of doing things.

She had an average IQ.

RADAR case example

Jane

Jane was 6 years old when assessed in the research clinic. Jane's biological parents were neglectful of her as a result of persistent drug and alcohol misuse. Jane was taken into foster care at the age of 1 year because of concerns about neglect and physical abuse and was adopted at 4 years old.

Jane was reported to be a difficult girl by her adoptive parents who felt she had serious difficulty in forming relationships with children or adults. She was extremely eager to please in social situations and would speak to strangers, wander away with them or seek physical contact with them. She was, however, very unpredictable with her parents, especially when reunited after short separations, even at the end of the school day.

Presentation

Jane did not appear shy and she was immediately at ease with unfamiliar adults and wandered away from her mother in the waiting room. She made great efforts to control the adult researcher and disclosed a great amount of personal information without being asked. She attempted to find out personal details about the research staff and became sullen, angry and down on herself when she felt staff were not answering her questions. She would look to her mother for some guidance but would generally ignore her advice or support. Jane managed to separate *from her mother* appropriately for research tasks initially but after spending a short time with research staff she became agitated and needed to make contact with her mother to check that she had not left the clinic.

Assessment at clinic

Jane required a great deal of support to remain focussed on the tasks that she was undertaking and seemed agitated. Her current attachment was rated as insecure-ambivalent as a result of her answers in the Manchester Child Assessment Story Task. Based on parental report and observation in the clinic, she appeared to have some difficulties with symptoms in the domain of Attention Hyperactivity Disorder.

Jane's mother was extremely worried about Jane's capacity to form appropriate social relationships with other children and adults and felt this was as a consequence of her early maltreatment and abuse. She felt that Jane had few boundaries, was highly strung and that Jane was always concerned that she was going to be left alone or be rejected. A semi-structured parental interview for autism spectrum conditions using the 3di (Skuse *et al.* 2004) suggested that Jane had some pragmatic difficulties, but did not fulfill criteria for an autism spectrum disorder. Her verbal IQ was in the low average range. Jane met diagnostic criteria for RAD (mixed symptom profile).

Discussion

The two cases described here are representative of the cases seen by Bowlby and by the RADAR study some 60 years later. Although in 1944 'indiscriminate friendliness' had not been described, we can infer its presence from the contrasting descriptions in Bowlby's series of 'affectionless' behaviour in the family setting and 'engaging' behaviour with strangers in the clinic. Bowlby's conceptualization of the aetiology of the cases differs in a number of ways from our own. First, Bowlby hypothesized that it was the impact of the separation and the subsequent loss that the child had suffered that led to the development of childhood disorder. This emphasis on the stressful nature of separation stimulated the development of attachment research (Rutter 1995). There is however, a growing consensus that the key aetiological factor in cases like those presented here is maltreatment (AACAP Official Action 2005) and it looks likely, when re-reading the Bowlby case studies now, that these 'affectionless' children were maltreated before, during and/or after their separations. Ironically, attachment theory may have had a weaker role to play in the understanding of 'juvenile thieves' because, to quote (Rutter 1995) 'the adverse environments that predispose to attachment insecurity usually include a wide range of risk features that may have nothing much to do with attachment as such' (p. 558).

Second, Bowlby appears to have viewed the children's difficulties as having essentially an environmental aetiology, which fits well with current ICD and DSM definitions of RAD (see Table 2). However, recent literature suggests that these are children with a high degree of complexity (Richters & Volkmar 1994; O'Connor & Rutter 2000; Boris *et al.* 2004; Roy *et al.* 2004; Zeanah & Smyke 2008) suggesting that both nature and nurture play a significant part in the development of this disorder (O'Connor & Rutter 2000; Minnis *et al.* 2007).

Third, insecure attachment in itself is not a disorder and secure current attachment patterns are consistent with RAD (Minnis *et al.* 2009). Our hypothesis and that of others is that insecure attachment is a significant risk factor for the development of disorder but this must be interacting with other important environmental and/or genetic factors for RAD to develop

(Green & Goldwyn 2002; Minnis *et al*. 2006). In child psychiatric populations, insecure attachment is likely to be the norm and is thus not a particularly useful measure of the severity of difficulties, although helpful for holistic assessment (O'Connor & Byrne, 2007).

We have previously argued that RAD may be a disorder of attunement (the carers ability to develop an appropriately aware, responsive and harmonious relationship with the child), rather than a disorder of attachment per se (Minnis *et al*. 2006) and that this may be a more helpful way to think about aetiology, treatment and prognosis. If RAD is assumed to have developed because of very poor or non-existent parent–infant attunement, it would be expected to affect all domains of social interaction. Interventions, particularly for older children, may need to focus on broader aspects of social interaction than parent–child attachment. This is not to diminish the crucial role of attachment theory in understanding these children and their difficulties. In our clinic, we routinely use assessments of attachment patterns (e.g. the Manchester Child Attachment Story Task) when evaluating children with RAD. A thorough understanding of how children react and use parents for support when under stress is a fundamental part of a holistic assessment of these children, which needs to also explore their interactions with strangers and peers. Neither would we wish to diminish Bowlby's contribution to the understanding of young offenders. His careful clinical descriptions of these children and equally careful consideration of potential aetiological factors spawned one of the most important research fields of the 20th century and has provided an important framework from which this research can broaden out.

Key messages

- Bowlby identified cases which we would now conceptualize as suffering from RAD.
- Bowlby thought that the main aetiological factor in developing these children's difficulties was separation. We now suspect that the main aetiological factor was maltreatment but that RAD arises from a complex interplay of genetics and environment.
- Insecure attachment is likely to be very common in child psychiatric populations and although its measurement is useful to develop a holistic understanding of the child, is not an indication of disorder in itself.

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