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**Editorial** **Open Access**

# Attachment Insecurity or Disorder: A dichotomy worth revising?

Pernille Darling[1] & Warren Ponder[2]

[1]Center for Evidence-Based Psychiatry, Psychiatric Research Unit, Psychiatry Region Zealand, Slagelse, Denmark
[2]Outcomes and Evaluation, One Tribe Foundation, Texas, United States

***Corresponding author:** ped@hejmdal.dk

It is well-established that whether we view the world as a safe place or a source of imminent danger, it is a determining factor in the quality of our relationships and general development across the lifespan. Together, Ainsworth and Bowlby wanted to investigate relational and interpersonal dynamics, trying to understand the evolution of "attachment patterns" from a young age over the course of a lifetime (1, 2). Bowlby posits two main concepts: that these attachment patterns are a result of the environment in which individuals were raised, and that attachment patterns are abiding but can be modified over the course of an individual's life (1). These foundational beginnings have paved the way for extensive research into the realm of attachment, shedding light on how early caregiving experiences shape attachment security or insecurity.

A growing body of scholarship clarifies that attachment insecurity increases the risk of developing mental disorders (3). Yet, intriguingly, attachment insecurity is not considered pathological but rather an adaptive response to caregiver sensitivity. Attachment disorders, on the other hand, are not commonly experienced but require clinical intervention. In the peer-reviewed literature, however, there appears to be a paucity of literature on how to diagnose attachment disorders and how to differentiate them from attachment disorganization, which also is considered a type of insecure attachment affecting individuals' emotional well-being. Nonetheless, there is research (4) suggesting that inhibited Reactive Attachment Disorder (RAD) "may be viewed as an extreme indication of disorganization" (5). This poses a significant question: are attachment disorders and attachment insecurity truly distinct concepts, or are they interlinked on a broader attachment spectrum?

As one digs deeper into the complexities of attachment and disentangle the operationalization and diagnostic criteria, it paints a picture that distinguishing attachment disorders from attachment insecurity is not a straightforward task. The Diagnostic and Statistical Manual of Mental Disorders-5-Text Revision (DSM-5-TR; American Psychiatric Association, 2022) defines RAD as a pattern of inhibited emotional withdrawal toward adult caregivers, accompanied by social and emotional disturbances. However, as we explore the intricate world of attachment, it is evident that attachment disorders have not been studied in a systematic manner (9). It has further been suggested that attachment disorganization may represent the gray area between attachment insecurity and attachment disorders (13). This points to the possibility that we should consider attachment difficulties, in any form, as part of the same spectrum.

The relationship between attachment insecurity, attachment disorders, and attachment disorganization raises crucial questions for both clinical practice and future research. How can clinicians differentiate between attachment disorganization and attachment disorders? Is it beneficial to consider them as two entirely different constructs, or might it make more sense to view them on a continuum? The literature presents various viewpoints on these matters, underscoring the need for further examination and understanding.

Attachment theory, which originated in the aftermath of World War II, laid the foundation for subsequent research by luminaries such as Bowlby and Ainsworth (8). According to attachment theory, children develop attachment strategies that complement the caregiver's sensitivity and responsiveness (19-21). Any instability or unreliability in these early caregiving experiences can impede the development of a secure attachment representation, which serves as the cornerstone for

later emotional development (22). This, in turn, influences an individual's ability to regulate their emotions and cope with adversity and stressful life events in adulthood (23,24).

It is evident that attachment styles and representations can evolve and transform over an individual's lifetime, shifting from insecure to secure as they encounter different life experiences. However, the study of attachment is not without its methodological challenges, such as the reliance on self-report measures and diagnostic interviews, which can complicate our understanding of these complex constructs. These uncertainties are mirrored in the evolution of the diagnosis of RAD from the DSM-IV (with its distinctions between emotionally withdrawn/inhibited and social/disinhibited types) to the most recent iteration, DSM-5-TR.

Within the DSM-5, RAD is categorized under trauma-and stressor-related disorders, presenting with common clinical features like dissociation, anhedonia, dysphoria, and externalizing behaviors, often accompanied by aggressive symptoms (6). It is noted that children with RAD are believed to have the capacity to form selective attachments, but paradoxically, when distressed, they often fail to consistently seek comfort, support, nurturance, or protection from caregivers (6). This description intriguingly mirrors the behavior seen in insecure (specifically, fearful) attachment among infants (7,25).

Rather than adhering to the reductionistic approach outlined in the DSM-5, an alternative perspective to consider is the attachment behavioral system. Mikulincer and Shaver (8) propose a comprehensive framework that includes the primary strategy of proximity seeking, which aims to secure support from a caregiving attachment figure. Additionally, secondary strategies, such as attachment anxiety and attachment avoidance, come into play when the attachment figure is perceived as unavailable or unresponsive. Bowlby extended his understanding of the attachment behavioral system by introducing the caregiving behavioral system that parents use to soothe their children, guided by their own internal working models. Ainsworth's early insights into the caregiving system shed light on how parents aim to eradicate their infant's distress when the infant perceives a threat, thereby activating their attachment behavioral system (26, 27). These two systems are conceptually intertwined, each complementing the other. When the attachment behavioral system is activated, the individual seeks proximity to the attachment figure, ideally a "safe haven," as originally proposed by Bowlby. Collins and colleagues emphasize that the caregiving system is activated when an individual subjectively perceives a threat and desires help and growth opportunities (28). Research further corroborates the significance of parental sensitivity in fostering child attachment security, with maternal and paternal sensitivity being linked to child attachment security, albeit with varying effect sizes (29,30). Encouragingly, interventions that enhance parental sensitivity have been associated with improved treatment outcomes (31).

While the description of RAD symptoms in the DSM-5-TR closely aligns with insecure attachment, it is essential to remember that this alignment does not mark the end of scholarship or theoretical exploration. Different stakeholders, including clinicians and agency administrators, possess distinct aims in their approach. For mental health professionals, the primary goal is symptom reduction, while agency administrators focus on optimizing the number of visits to maintain cost-effectiveness. Clinical practices, particularly those targeting individuals with attachment difficulties, often employ a "global" attachment perspective as a foundation for treatment plans, highlighting the potential for attachment style transformation from insecure to secure over the course of treatment (32).

While attachment insecurity is widely recognized as a risk factor, it becomes essential to differentiate when it becomes a disorder rather than an extensive adaptation to survive, especially when extreme environmental factors are less evident. The core query revolves around the significant differences in clinical approaches to attachment insecurity versus attachment disorders and the continuous assertion of an unclear association between attachment representation and attachment disorders. We acknowledge the substantial impact of adapting to inadequate caregiving, and it is evident that attachment disorders and attachment disorganization both arise from poor-quality caregiving (34). Bowlby's framework outlines five therapeutic tasks that clinicians can employ to address insecure attachment, including providing a safe haven and secure base, exploring interpersonal relationships, examining the clinician-client dynamic, and understanding how early working models adapt over time (22).

In conclusion, we must question whether the available research is sufficient to conclude that attachment insecurity and attachment disorders are distinct constructs rather than varying degrees of severity on a continuum. From a rational perspective, it is challenging to dismiss the interrelationship between attachment disorganization and disordered attachment. Perhaps a lack of quality methods hinders our ability to fully understand the complexities of the attachment system. Have we overestimated our capacity to compete with an inborn instinct that has ensured the survival of

humans and many animal species for millennia? Therefore, it is crucial and the next logical step to conduct a comprehensive examination of our methods and reevaluate.

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