Reactive Attachment Disorder: A New Branch of Autism?

The symptoms of Reactive Attachment Disorder closely resemble that of autism, however the two are considered separate according to the Diagnostic and Statistical Manual of Mental Disorders; is there any way to change this?

Tag Words: Reactive Attachment Disorder; Autism; RAD; ASD; Oppositional Defiant Disorder; Conduct Disorder; ODD; CD; Adoption; Foster Family; Diagnostic and Statistical Manual of Mental Disorders; DSM; Petition; change.org; Developmental Disorders; Attachment Disorders; Attachment; Autism Spectrum Disorders; Pervasive Developmental Disorders; Neglect; Stages of Development; Psychiatry; Orphanage

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Summary

Children with Reactive Attachment Disorder (RAD) have very limited means for help, according to today’s standards. Unfortunately, families of children afflicted with RAD are at a loss since this disorder does not receive enough support in the scientific community. The main problem is that Reactive Attachment Disorder has a very loose and faulty definition, and is extremely difficult to place into one specific category of disability. Our solution is to convince others that RAD is actually a branch of autism, and needs to be treated as such. Autism is a deteriorating developmental disorder that requires special resources, and is entitled to governmental assistance according to the Diagnostic and Statistical Manual of Mental Disorders (DSM). To go about changing this, we plan on writing a research paper linking Reactive Attachment Disorder with autism, in addition to a petition, to try to convince the authors of the DSM to rewrite the definition and include RAD as a subtype, ultimately resulting in more funding and more research.

Introduction to Developmental Disorders

Many parents agree that raising a child can be tough. There are obstacles to overcome at every age, and growth stages that need to be met appropriately by attentive parents. When these stages do not follow their normal route, the child may be suffering from something called a developmental disorder. While debilitating, these disorders often do not lead to permanent disablement, and some symptoms may even disappear with proper treatment. Conduct Disorder, for example, is a particularly dangerous neuropsychiatric disorder that seems to resolve itself
with age; unfortunately, the same cannot be said for many of the comorbid disabilities accompanying this disorder. Comorbidity will be readdressed later on in this paper.

Of course, raising such a child is by no means easy. These children require much more attention and care than children without developmental disorders. Often times these disorders develop in conjunction with personal traumas, starting as early as birth. It is a common misconception that any amount of suffering done to a child up until age 2 can eventually be reversed through psychology, however this is not always so. Between the ages of 1 and 2 years old, a person will learn approximately 75% of the knowledge he or she will ever know. Vital concepts like how he/she perceives the rest of the world, how he/she should interact with the surroundings, and how trusting he/she should be with those around her will be solidified by this age. Unfortunately, any trauma experienced by the child during this crucial time may set the child off with a rocky foundation; this is often how developmental disorders first come into being.

These disorders are never easy to diagnose with one hundred percent accuracy. In fact, previous diagnoses are often changed and may even be entirely disregarded with the appearance of new symptoms. It is crucial to always be on the lookout for additional symptoms, especially when treatments do not seem to be working properly. A good example of this is shown with a case study involving a troubled fourteen-year-old named Stephen. Early on, psychiatrists were able to diagnose Stephen with Conduct Disorder. He showed all of the obvious symptoms: outbursts of violence towards people and animals, destruction of property, defiance towards those in command, and a strive to gain emotional responses out of people. One thing no one seemed to pick up on, however, was the extraordinary impulsiveness behind many of his actions, a classic sign of Attention Deficit Hyperactive Disorder (ADHD). There are medications that target this particular combination of disorders, and it was not until Stephen landed himself in a troubled youth center that a proper analysis could be made. As such, there is a Diagnostic and Statistical Manual of Mental Disorders (DSM) that helps to compile and separate each disorder into different categories. It is our goal to reach out to the authors of the DSM and redefine some of the boundaries to help troubled kids afflicted with development disorders.

References
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Comorbidity and Development of Progressive Disorders

Children with developmental disorders rarely ever have one single problem. In fact, a very popular branch of modern study is something called, “comorbidity.” In essence, comorbid disorders are those that happen in conjunction with one another. Often times, a child who is afflicted with one condition ends up contracting others due to his or her disability. There may also be genetic evidence that leaves certain individuals prone to more than one type of neuro-psychiatric disorder. Whatever the cause may be, comorbidity is extremely common in patients
and leads to a very complex combinations of symptoms. In fact, most effective treatments cater to all comorbid disorders at once rather than dealing with each one consecutively. 1 Treating one disorder without affecting the other(s) will never really cure the patient, and will only lead to disheartening failures. By focusing on each condition collectively, one is able to narrow down the multitudes of treatments out there and find the one most effective for the patient.

One of the most common developmental diagnoses given to children involves a highly comorbid disorder called Oppositional Defiant Disorder (ODD). People with ODD tend to be outwardly aggressive towards their caretakers and like to irritate others in order to get a negative emotional response. Surprisingly, as common as ODD is in growing children and adolescents, very little research is spent on this subject. More often than not, research is conducted on many of its common comorbid conditions like ADHD and depression. According to one paper, in the past three years there have been 293 articles written in medical journals pertaining to ADHD and 276 pertaining to depression in children, yet only 19 articles have been written on ODD. Obviously, research is severely lacking in this department, which is a shame since disorders paired with ODD tend to have extenuated symptoms; often times, normal treatments are not effective without additional therapies. 1

In addition to comorbidity, a common problem that is often overlooked is the progression of neuropsychiatric disorders from one form to the next. Often times, a doctor comes up with an original prognosis, which seals the fate for future diagnoses; this is particularly common in children suffering from Conduct Disorder (CD), which will be discussed shortly. As children enter new stages of development, their problems develop alongside them and transform into new ones. For Oppositional Defiant Disorder, there are three main paths that doctors need to be aware of. First, ODD can be cured with no lingering side effects, however this is not the norm. Second, it can persist into adulthood, and what happens then all depends on the comorbid problems this person accumulates. Third, and probably worst of all, it can develop into CD, which is basically a much more violent version of ODD. In fact, diagnoses between the two are often ambiguous, with the only defining characteristic being whether or not one feels safe around the affected patient. Looking at comorbid conditions again is vital at this stage, since CD generally tends to resolve itself by adulthood (~70% of all cases), leaving only the comorbid effects behind. Luckily, there seems to be a very limited window for development of CD, and by the time the child is 4 years old chances are that he or she will no longer be able to contract this disorder. 1 Obviously, evolution of disorders can be quite complicated and certainly needs to be taken into account when developing proper treatments.

In summary, it is vital to be aware of the complex evolution of neuropsychiatric disorders in both their progression and involvement with comorbid conditions. Although many of the following conditions are going to be talked about as single entities (RAD in particular), it is much more important to look at the overlying picture and not focus on just one particular aspect. Curing the symptoms of one disorder is often only the first step in curing an individual. As such, this paper is designed to be a stepping-stone for future treatments to come.

References
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Importance of Attachment:

Attachment is one of those concepts that sheltered families tend to take advantage of; generally the mom will watch over the baby and care to its basic needs, while the baby in turn responds by “cooing” and giving her eye contact. Very few people realize that a huge amount of development is being obtained during this attachment process. A baby needs to learn from the mother that it is alright to trust her and cling onto her when needed. Of course, the only way to do this is if the mother takes a profound interest in the baby and devotes herself to spending time with him/her, which can be pretty challenging given today’s high-paced society. In fact, the amount of time spent in a daycare center or with a babysitter can be highly debilitating if it is not balanced with time spent with the mother. The attachment process is one of the earliest stages of development, and can be one of the deadliest if neglected.

Unfortunately, problems with attachment do not tend to disappear with age. This is why the initial bonding between a mother and child is so vital: it takes only three months for the bond to become solidified, and becomes increasingly harder to form after the baby reaches two months old. Of course additional relationships are going to be formed in adolescence, but they will always build off of this central relationship. One of the main reasons for this is because the attachment process, in essence, gives the child an initial sense of conscience. It serves as “the basis for development of basic trust or mistrust [in people], and shapes how the child will relate to the world, learn, and form relationships throughout life.” In such a manner, one learns to accept others and understand their desire to help. Of course when this bond is disrupted, babies never learn the importance for allowing people into their personal lives, and will probably have a tough time relating to anyone else. As explained by Kathy Miller, founder of The Attachment Network in Oklahoma, “When an infant expresses rage and feels no relief for his need, he learns that to survive this world, he must control it. These children actually believe that if they release control to anyone else that they will die.” This is why lack of attachment can be so dangerous; being unattached to the rest of society allows one to commit acts without remorse. These people are basically allowed to do whatever they want, and so many of them resort to vandalism and crime to release many of their angers. Some researchers claim that detachment can ultimately lead to psychopathy, yet there is still a lot of research to be done in this department.

It is not always easy to tell when a baby suffers from an attachment disorder, as they have a tough time expressing themselves at that age. A good test is to pick up a child and see if he or she tries to cling onto you; a detached baby will remain stiff as a board. A perfect example of a family who came to this realization much too late were the Scotts, who decided to adopt a five year old orphan named Danny. Abandoned at birth by his mother, Danny was quickly placed in an orphanage that did nothing to care for their young. By the time the Scotts were able to pour love and affection into Danny’s life, Danny had unfortunately learned to shy away from all emotion, and secretly he despised it. He hated his family, and during the time he lived with them had attempted to drown a little girl, vandalize a house worth $6000 in damages, start numerous fires around the neighborhood, and strangle at least three different cats. Eventually, the family was forced to give him up, as Danny’s hatred for them was tearing their entire foundation apart, and Danny vowed to get even with all of them one day. This just goes to show that love and affection is unfortunately not always the answer, especially when it comes too late in a child’s life. Attachment disorders can be disastrous and more people need to be aware of their effects before starting a family.
The Link Between Adoption and Developmental Disorders

Adoption is supposed to be a wonderful thing; it is the process by which unwanted children are made to feel loved and cared for once again. The child will grow up nourished, clothed, and happy, and will love his/her adopted family as if they are biologically related. This, of course, is an extremely idealized way of thinking about the whole adoption process. Most adopted children have gone through many hardships in their life, which as stated before can lead to some severe developmental problems. Many have become detached from the rest of society due to lack of care that many orphanages provide, which spells out disaster for the foster family. One of the biggest problems for adopted families is that they are not educated enough to understand all of this. Generally, no psychologist is guiding these families through the adoption process telling them exactly what to look out for, and certainly the orphanage itself is not going to provide any warnings. Asking questions is probably one of the most important things that a couple can do when adopting a child. Such things like knowing exactly what the child has gone through during his/her life, how long this child has been in the orphanage and at what age did he/she start, and what the reasons are for putting the child up for adoption in the first place can really help a family learn about the commitment they are about to make. Another important question to ask is whether or not there is any government funding available to pay for this child’s neuropsychiatric therapies, if he or she would ever require it. Again, adopted kids are much more likely to contract these types of disorders due to the chaotic nature of their lives, and it is always important to know what resources are at one’s disposal. 1

A study was actually conducted relating troubled toddlers to an attachment disorder called Reactive Attachment Disorder (RAD). In this study, 94 toddlers ages 10 to 47 months were chosen from a foster care in New Orleans, Louisiana and evaluated for any signs of RAD. Basically, what the researchers were doing was seeing if there was any increased likelihood to contract this disease after being placed in foster care during a crucial time of development. In the end, two major conclusions could be made in regards to RAD and the adoption process. As suspected, there was a positive correlation between RAD contraction and being placed in a foster home, but there was also an increased rate of co-occurrence between the two types of RAD 2, both of which will be explained in the next section. There are still so many things people do not understand about the RAD contraction process, and studies like these really help to fill in the gaps.

References
Symptoms for Reactive Attachment Disorder

Reactive Attachment Disorder encompasses everything that has been discussed thus far. First introduced in 1980 in the Diagnostic and Statistical Manual of Mental Disorders: Third Edition (DSM-III), RAD has since undergone significant changes within its diagnostic criteria. To illustrate, the first definition described RAD as having an “onset before eight months of age.” After the third edition was revised (DSM-III-R), however, the onset became before five years of age. Today, the most recent diagnosis criteria for RAD is described as “markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years…” To further complicate things, RAD is also diagnosed with either one of two subtypes, or possibly even both. Recent studies have shown that some children may exhibit both due to severe emotional deprivation. Either way, both types result from “persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection; persistent disregard for the child’s basic physical needs; and/or repeated changes of primary caregiver that prevent formation of stable attachments.”

The first subtype of RAD is known as the “inhibited type,” in which the child responds to common interactions with opposing reaction. In other words, “the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting…” For example, in times when a young child usually seeks comfort from a preferred caregiver and responds to the comfort that is given, children with the inhibited type of RAD display abnormal reactions. Generally, they do not look for comfort from others and, at times, may be afraid to seek consolation, regardless of obvious despair. Moreover, if comfort is given, these children either fail to respond or resist altogether. Usually, these responses occur over a period of time rather than all at once. In addition, “This pattern of RAD has been identified in children with histories of maltreatment and in children who are being reared in institutions,” proving once again the significance of proper child rearing. Furthermore, children with this particular subtype may also have difficulties in controlling their emotions. For instance, the child may show no positive reactions at times when it is expected, have unforeseen bouts of crying, constant irritability, or show anger and/or even aggression in response to comforting acts.

The second subtype of RAD, or the “disinhibited type,” occurs when a child either seeks attention from strangers or lacks judgment when choosing who he/she becomes close to. Instead, this child usually “forms attachments to just about anyone.” More specifically, these children may approach strangers with no discretion, look for and even sometimes accept the comfort of strangers, object to being separated from strangers, or roam away from their caregiver with total disregard. They refuse to seek comfort from discriminated attachment figures but are willing to seek and accept it from anyone else. Sometimes, they are considered “attention seeking, shallow, and superficial interpersonally” due to the lack of emotion they share with those who care about them. This type of RAD has also been seen in children who have been mistreated and children who have been institutionalized. Though it has been proven that some attachment occurs after a child has been adopted and placed in a better environment, disinhibited behaviors still linger for numerous years.
References


Present-Day Definition for Autism

Usually when one thinks of autism, he/she pictures a person with the severest form of the disorder. Despite this familiar image, “autism” is used to classify a wider range of disorders than most are aware; these disorders are known as Autism Spectrum Disorders (ASD). As the name suggests, there is a wide variety of intensities, symptoms and behaviors, types, and even individual variations. These disorders include Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder Not Otherwise Specified (including atypical autism), and can range from non-verbal and asocial to high-functioning modes of personality. With so many different subtypes, diagnosing ASD can be quite difficult. Luckily, many of these behaviors can be seen in the distinctive forms of play and through the various social skills children have. In the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, Text Revision (DSM-IV-TR), these disorders are found under the title of “Pervasive Developmental Disorders.” 1 Usually evident within the first few years of a child’s life,

Pervasive Developmental Disorders [PDDs] are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual’s developmental level or mental age. 2

In other words, these disorders are distinguished by age, onset, severity of symptoms, speech delay, and intellectual disability. 3

According to the DSM-IV-TR, Autistic Disorder has an onset prior to 3 years with the presence of qualitative impairment in social interaction, communication, and limited recurring
and predictable patterns of behavior. Social interaction impairment is characterized by trouble “in the use of multiple nonverbal behaviors...; failure to develop peer relationships...; a lack of spontaneous seeking to share enjoyment, interests or achievements with other people; [and/or] lack of social or emotional reciprocity”. Communication impairment includes a developmental delay in speech, or lack thereof; an inability to start or hold a conversation with others (found in those that have developed adequate speech); repetitive use of language; and/or “lack of varied, spontaneous, make-believe play or social imitative play appropriate to developmental level”. The latter set of conditions, of course, can be related to social interaction impairments as well. Meanwhile, limited recurring and predictable patterns of behavior include abnormal fixations and limited interests, recurring hand and finger movements, entire body gestures, habitual behaviors, and an obsession with certain parts of an object, which ultimately means “repetitive use of objects and unusual sensory seeking behaviors”. Most of the children with ASD exhibit lots of communication and social interaction impairments, however, limited recurring and predictable patterns of behaviors are much more variable amongst these children. This leads to the question of whether or not these behavior patterns are necessary for the diagnosis. Nevertheless, examination has shown that most children with ASD have displayed various types of these behaviors up until they reach their teens. Studies have also implied that ASD diagnoses are usually more accurate when these behaviors are included as part of the criteria.

Just like RAD, studies have shown that autism is most certainly a neurodevelopmental disorder, however, there are still no biological tests that can help diagnose it. At the same time, it has been proven that ASD is more prevalent in males seeing as it occurs 4 times more often in males than it does in females. In addition, “intellectual disability frequently co-occurs with ASD, although the percentage of co-occurrences has reduced from 75% to 50% over recent decades.” Other studies, though unreliable, have even suggested that relatively older parents give way to an increased risk of ASD.

References

ASD vs. RAD

After analyzing both types of disorders, it becomes apparent that many symptoms tend to overlap. In fact, diagnosing one disorder over the other often times will not explain all of the symptoms present. For instance, when RAD was diagnosed in a child, it would not help to explain the recurring behaviors and speech delay. When ASD was diagnosed, it would not help to explain why a child lacked essential bonds with his/her caregiver. On the other hand, if the diagnoses had been combined, or co-existed, they would help to explain what the other could not. Being a spectrum disorder, it is not farfetched to say that RAD could possibly be included within the ASD spectrum.
Unfortunately, there has been significantly less research done on Reactive Attachment Disorder than on the Autism Spectrum Disorder. As previously mentioned, this is due to the fact that some disorders just get more focus, regardless of how frequently they actually occur. What is known, however, is that RAD very much so resembles certain characteristics of ASD, to the point where a lot of confusion amongst regular, everyday people occurs. “The presence of inappropriate social interaction delays in language development and deficits in communication skills and self-stimulating behaviors in children with RAD cause difficulties in differentiating this condition from autistic disorders.” In spite of this, when looking up RAD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), one will be sure to find a disclaimer under the heading of “Differential Diagnosis” that reads

[RAD] must be differentiated from Autistic Disorder and other Pervasive Developmental Disorders. In the Pervasive Developmental Disorders, selective attachments either fail to develop or are highly deviant, but this usually occurs in the face of a reasonably supportive psychosocial environment. Autistic Disorder and other Pervasive Developmental Disorders are also characterized by the presence of a qualitative impairment in communication and restricted, repetitive, and stereotyped patterns of behavior. Reactive Attachment Disorder is not diagnosed if the criteria are met for a Pervasive Developmental Disorder.

Essentially, what is being said here is that in order for RAD to be diagnosed, PDD, and thusly ASD, must be ruled out first.

In addition, this disclaimer, along with its scientific definition, fails to identify the significance of RAD. Furthermore, there has been very little research on the outcome of certain treatments of RAD. These treatments are usually considered more difficult because there tends to be other mental, medical, and developmental conditions that need to be considered and treated. Nevertheless, it has been said that in order to make a distinction between the RAD and ASD, responses to treatment must be analyzed. Even so, there are ranges of treatments that are used to address both RAD and ASD. Such treatments include “psychoeducational treatment, social skills programming, behavioral modifications and parent support programs,” which are most effective in a child’s earlier developmental stage. In addition, the value of such treatments is also increased when a caregiver is involved.

One particular study took a total of 21 children with ASD and RAD: ten with ASD and the remaining 11 with RAD. All of the children were between 24 and 70 months. In this study, a 14-session program was designed to establish an interaction between the children and their caregivers, as well as “provide an educational program for emotional, social, and language development.” In the end, both groups of children displayed significant changes. Moreover, “the children with RAD showed greater improvement than the autism group in their total development score, on the language-cognitive subscale, and in social/self-care abilities.” Regardless of studies such as these, the DSM still makes sure to establish that RAD and ASD are not the same. With the last sentence saying “Reactive Attachment Disorder is not diagnosed if the criteria are met for a Pervasive Developmental Disorder,” RAD is pushed aside and is presumed inferior to all Pervasive Developmental Disorders. In other words, RAD is the last resort when a PDD is not diagnosed. However, this is certainly not the case. Not only are the two similar in description, but they also respond similarly to certain treatments, helping to disprove their differentiation.
Conclusion

(WD) As stated previously, many developmental disorders are sorely under-researched and certainly underfunded. There are a lot of comorbid conditions that gain a lot more attention than these disorders 1, and it is our goal to see if we can shift some of this attention towards some of the more general attachment disorders. By relating Reactive Attachment Disorder to autism, our hope is to get the authors of the DSM to redefine their definitions and start pairing the two together. Hopefully, this will generate more research projects related to RAD, which can ultimately be applied to other attachment disorders in general. While the main intent of this paper is to change the way people look at autism and RAD, it should not be limited to just these two disorders. Numerous examples such as Oppositional Defiant Disorder and Conduct Disorder have been utilized throughout this paper to explain the complex nature of neuropsychiatric conditions. These complexities make it very difficult to define concrete boundaries, and so numerous scientific debates call for constant revisions in the realm of psychiatry. Papers like these should be used to question the most up-to-date definitions and promote thinking and learning in all types of sciences.

In the end, if nothing were to change, then I urge the authors to at least try and convince psychiatrists to look into Reactive Attachment Disorder with the same keen interest and concern as autism. I understand that it is hard for one paper to change the opinion of a whole council of psychiatrists in charge of publishing the DSM, but it is our intent to at least get them thinking about RAD in a new context. Ultimately, this is a small step towards gaining knowledge and pouring capital into areas of research that are extremely lacking in today’s society.

References

[1] Chandler, James. *Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) in Children and Adolescents: Diagnosis and Treatment*. Print.
Petition to the American Psychiatric Association

(JR) In May of 2013, a new edition of the *Diagnostic and Statistical Manual of Mental Disorders* is scheduled to be published. Prior to its publication, the American Psychiatric Association has had “commenting periods” in which the public was allowed to review these new changes and suggest their own ideas and revisions. In fact, there is another “commenting period” coming this spring of 2012. To promote the change in definition, we decided to write a petition using change.org. Once it has reached 100+ signatures, this petition will be sent to the APA in hopes of Reactive Attachment Disorder being added under the Autism Spectrum Disorder. This is what we plan on telling them:

We would like to take the time to inform you about a particular issue we feel needs more attention in the psychiatric community: Reactive Attachment Disorder. This developmental disorder seems to have some vague diagnostic criteria, and most people are not even aware that this problem exists. It is particularly prevalent in adopted children, and can be dangerous if not taken into account.

Below, we have attached a link to a petition to get RAD included as an Autism Spectrum Disorder. This inclusion could potentially give rise to more attention on RAD, and may even stimulate new research on the matter. We encourage you to read over our research proposal explaining the need for such a change. The link to this paper is also provided below.

Thank you for taking the time to read this.

Sincerely,

William Ditchik and Joelle Ramey


Research Paper Link: (this link will be provided once our “Classipedias” are published.)
Here is a copy of our petition:

We’ve done the research. We know what it’s about. Reactive Attachment Disorder, or RAD for short, is a debilitating developmental disorder that afflicts many troubled youths. This disorder leaves individuals detached from the rest of society, unable to form the nurturing bonds that we as a [social] species desperately need. It often plagues infants that are forced to endure prolonged suffering, such as adoption and neglect.

Today, it is common practice for psychiatrists to diagnose their patients with RAD when nothing else seems relevant, and autism seems to be too farfetched. They hand this disorder off as a last-ditch attempt to come up with a prognosis. This is a huge problem because Reactive Attachment Disorder is not something that should be handled so carelessly; the lack of human interest shown by people with RAD often leads to a lack of emotional conscience, which very well may lead to increased acts of violence and crime. More funds need to be diverted towards this sorely misunderstood subject, and lots more research needs to be conducted.

According to the newest [unpublished] edition of the Diagnostic and Statistical Manual of Developmental Disorders (DSM), Reactive Attachment Disorder falls outside the realm of autistic disorders, and as such will not gain the same fame and attention as its famed counterpart. The chilling fact remains that RAD and autism share many common characteristics, and in fact are built upon similar foundations (except for genetics). By signing below, I am urging the authors to reconsider their definition of autism to include RAD as a subtype before this new edition gets published; it is our sincere hope that in this manner, Reactive Attachment Disorder can share in the same focus as autism in the eyes of the scientific community. (WD)

Thus far, we have been successful with gathering friends and family to help our cause. In addition, we have received other signatures of people that we do not know personally. One particular signee had a child with RAD, but due to severe complications, found it necessary to give her up after seven years.1 Hopefully, the petition will get the recognition it needs in time for the last “commenting period.”

References
Letter to the Editor (WD)

The New York Times

Dear Editor:

Words change and definitions are altered; previously constructed concepts become meaningless as these changes progress. Benedict Carey clearly explains this concept in her article, “Where Have All the Neurotics Gone?” (published March 31, 2012), when she talks about how the term “neurotic” has lost most of its meaning in today’s society. The realm of psychiatry sees many of these cultural shifts, and so the American Psychiatric Association periodically revises and republishes the Diagnostic and Statistical Manual for Mental Disorders.

Recent patterns show that while Autism and Attention Deficit (Hyperactivity) Disorder continue to be at the forefront of psychiatric research, disorders such as Reactive Attachment Disorder and Conduct Disorder seem to fade into obscurity. With new definitions for Autism effectively isolating these disorders, continued research may become limited. Perhaps some alterations to these definitions should be considered before final publication of the latest DSM.

Letter to the Editor (JR)

The Star Ledger

With Autism Awareness Month being among us, there has been plenty of talk regarding the Autism Spectrum Disorder (ASD). In addition, the article “N.J. still ranks high in autism rate, report says” (March 29) also announced that the federal Center for Disease Control and Prevention recently released studies that show ASD is prevalent in about 1 in every 50 children in New Jersey. Such attention makes it easier to overlook, or even downplay, many other developmental disabilities affecting today’s youth.

This includes the lesser-known Reactive Attachment Disorder (RAD). Though it is mainly found in adopted children or children of foster care, RAD is a disorder that can affect anyone who was neglected in their early developmental stages, limiting him/her from forming the necessary bonds to what many refer to as “loved ones”. So often its diagnosis is the last resort when the criteria for ASD have been exhausted, further putting its research on the backburner.

Before its publication in May 2013, there is a petition at http://www.change.org/petitions/american-psychiatric-association-add-reactive-attachment-disorder-under-the-autism-spectrum-in-the-new-dsm to get the American Psychiatric Association to add RAD to the Autism Spectrum Disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in order to get RAD the attention it needs.