Autism and Attachment: A Need for Conceptual Clarity

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It is not uncommon to hear clinicians and practice-focused researchers speak of an overlap in critical features between autism spectrum conditions (hereafter autism) and the various attachment disorders and patterns [1, 2]. The argument follows that there are times when it can be difficult to differentiate what is 'autism-related' from what is 'attachment-related'. Much of the empirical work on this topic has focused on the differentials between autism and the '*attachment disorders*' and in particular *reactive attachment disorder*. Yet some researchers and clinicians have suggested that the symptomatic similarities extend into the broader category of '*attachment difficulties*'. So what do we mean by 'attachment disorders'? Is there a meaningful distinction between these disorders and 'attachment difficulties'? And where is the overlap with autism?

What is autism?

Autism is defined as a lifelong developmental condition which is manifest through atypical social communication (e.g. atypical eye contact and difficulties with some aspects of social understanding/interaction) and behaviours deemed restricted and repetitive (e.g. hand-flapping, intense or circumscribed interests)[3] Autism features in the neurodevelopmental constellation and is considered, by most, to be present from birth and multifactorial. Establishing the biomedical causes has proved particularly complex, nevertheless, there are a robust suite of standardised assessments which have been shown to reliably measure autism. Although autism almost certainly has multiple causes, there is ***no*** known association with maltreatment or early adversity.

What are 'attachment disorders'?

'Attachment disorders' are diagnoses which are sometimes applied to children who have experienced significant patterns of insufficient care. According to classification systems, there are two types of these conditions: Reactive Attachment Disorder (hereafter RAD) and Disinhibited Social Engagement Disorder (hereafter DSED) [3] Underpinning both of these conceptualisations is the idea that there has been a complete collapse of the attachment system as a result of extremely limited opportunities to forge a relationship with an attachment figure [4, 5]. Both RAD and DSED are characterised by atypical social responsiveness [3], although, they diverge in the nature of these social behaviours. Specifically, RAD is associated with 'inhibited' behaviours which mirror 'internalising' conditions, while DSED is associated with more 'disinhibited' behaviour which are closer to those seen in children with 'externalising' conditions.

To date there has been little agreement, among researchers, regarding the prevalence of attachment disorders. Some researchers maintain that they are rare even among high risk populations (e.g. children who have experienced institutional

care)[6]. Whereas others argue that relatively high rates of attachment disorders can be observed in some samples even within the general population[7]. Yet these debates are part of a wider conversation regarding which symptoms are considered part of RAD [8]. For some, RAD is characterised by the absence of behaviours targeted toward an attachment figure, atypical comfort seeking/accepting behaviours in response to distress, atypical socio-emotional responsiveness, limited positive affect, and frightfulness [9, 10]. This understanding of RAD is closely tied with the descriptions contained in current nosologies [3]. In contrast, others have interpreted the diagnostic criteria regarding '*minimal social responsiveness to others'[3]* to include symptoms such as avoiding eye and physical contact, as well as difficulties with being affectionate. [11] This description of RAD is more aligned with the assessment tool *The Child and Adolescent Psychiatric Assessment* (CAPA-RAD) [12].

Symptomatic similarities between RAD and Autism

The thread of atypical social responsiveness and atypical positive affect runs through both autism and RAD. Previous work has observed inflated rates of autism-behaviours in children who have experienced institutional deprivation.[13] Specifically, these studies found that children who had experienced institutional deprivation had atypical social and communication behaviours comparable to that which is typically seen in children with autism. Crucially, however, there was often a marked change in these behaviours when the child entered a more adaptive environment [14], which is not typically the case with autism.

Subsequent work comparing children with autism and children with RAD found that a substantial number of children with RAD scored in the clinical range on the social domain for autism on gold standard assessments.[15] Diagnostic guidelines [3] acknowledge these symptomatic similarities and suggest that restricted and repetitive behaviour may be differential. Yet the authors of the aforementioned study [15] found that 20% of the children with RAD also demonstrated clinically significant levels of restricted and repetitive behaviours.

Unsurprisingly, the overlap becomes more acute when symptoms such as avoiding eye contact are included in the conceptualisation and assessment of RAD. For instance, Davidson and colleagues [16] observed that children with autism can score in the clinical range on RAD assessments measures.

This does not, of course, suggest a possible epidemic of 'misdiagnosis'. Rather, it serves as a reminder of the limitations of assessment tools, and underscores the importance of clinical judgment in making a diagnosis. Or to echo the words of Prof Catherine Lord at the recent ACAMH Jack Tizard Memorial Lecture and Conference, "The ADOS is a measurement, not an answer".

Attachment difficulties

When thinking about the overlap with autism, some clinically-focused researchers have argued that the definitions of RAD and DAD are too restrictive [2, 17]. Instead, these commentators suggest that the overlap extends to the wider category of 'attachment difficulties'. The phrase 'attachment difficulties' is often used as a suitcase term for the attachment classifications (insecure and disorganised), as well the 'attachment disorders'.

In accordance with this view, some practice-focused researchers have also started to develop tools which seek to differentiate between autism and attachment difficulties. Examples include The Coventry Grid [2] and The Coventry Grid Interview [17]. Both of these instruments place emphasis on the 'emotional feel' of symptoms and have been developed on the basis of clinical experience and clinical consensus. Many of the psychometric properties of these tools are yet to be established, however several NHS services do claim to use them. Importantly, the authors of each of these assessments all acknowledge that these instruments are not a straightforward guide to differentiation, but rather a possible complement to the information gathering process.
Whether these tools can accurately differentiate attachment difficulties from autism-related behaviours seems to be an open empirical question.

Differentials

Perhaps the most important differential between autism and the attachment disorders is a history of insufficient care. In the absence of such a history it is unlikely that the child will meet the diagnostic criteria for either of the attachment disorders. Yet this is not such a clear cut indicator when thinking about attachment difficulties more generally, given that neither insecure nor disorganised attachment imply neglect or insufficient care [18].
There is also some emerging evidence that children with autism may be more likely to have an uneven cognitive profile, that is, a significant difference between performance and verbal IQ. [19] Such profiles are not typically reported in children with attachment difficulties in general or attachment disorders specifically. Obviously more research is required, but this is an intriguing line of inquiry.

Conclusion

The symptoms of autism and the various attachment conditions converge and depart in interesting ways. Yet the extent to which they overlap is closely tied to how the researcher or practitioner conceptualises 'attachment disorders' or indeed 'attachment difficulties'. Standardised measures alone may not be a robust differentiator, thus underscoring the importance of clinical judgment and a greater focus on developmental history in the diagnostic workup. While certain tools might be helpful in the information gathering process, it is particularly important to consider how they conceptualise the conditions they are comparing.

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