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31.11a Reactive Attachment Disorder and Disinhibited Social Engagement Disorder

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behaviors in a young child that reflect grossly negligent parenting and maltreatment that disrupted the development of normal attachment behavior. A diagnosis of either reactive attachment disorder or disinhibited social engagement disorder is based on the presumption that the etiology is directly linked to the caregiving deprivation experienced by the child. The diagnosis of reactive attachment disorder was first defined in the DSM, Third Edition (DSM-III) in 1980. The formation of this diagnosis is based on the building blocks of attachment theory, which describes the quality of a child's affective relationship with primary caregivers, usually parents. This basic relationship is the product of a young child's need for protection, nurturance, and comfort and the interaction of the parents and child in fulfilling these needs. Based on observations of a young child and parents during a brief separation and

reunion, designated the "strange situation procedure," pioneered by Mary Ainsworth and colleagues, researchers have designated a child's basic pattern of attachment to be characterized as secure, insecure, or disorganized. Children who exhibit secure attachment behavior are believed to experience their caregivers as emotionally available and appear to be more exploratory and well adjusted than children who exhibit insecure or disorganized attachment behavior. Insecure attachment is believed to result from a young child's perception that the caregiver is not consistently available, whereas disorganized attachment behavior in a child is believed to result from experiencing both the need for proximity to the caregiver and apprehension in approaching the caregiver. These early patterns of attachment are believed to influence a child's future capacities for affect regulation, self-soothing, and relationship building. According to the DSM-5, reactive attachment disorder is characterized by a consistent pattern of emotionally withdrawn responses toward adult caregivers, limited positive affect, sadness, and minimal social responsiveness to others, and concomitant neglect, deprivation, and lack of appropriate nurturance from caregivers. It is presumed that reactive attachment disorder is due to grossly pathological caregiving received by the child. The pattern of care may exhibit disregard for a child's emotional or physical needs or repeated changes of caregivers, as when a child is frequently relocated during foster care. Reactive attachment disorder is not accounted for by autism spectrum disorder, and the child must have a developmental age of at least 9 months. Pathological caretaking can result in two distinct disorders: reactive attachment disorder, in which the disturbance takes the form of the child's constantly failing to initiate and respond to most social interactions in a developmentally normal way; and disinhibited social engagement disorder, in which the disturbance takes the form of undifferentiated, unselective, and inappropriate social relatedness, with familiar and unfamiliar adults. In disinhibited social engagement disorder, according to DSM-5, a child actively approaches and interacts with unfamiliar adults in an overly familiar way, either verbally or physically. There is diminished checking with or seeking of a known caregiver, and a willingness to go with unfamiliar adults without hesitation. These behaviors in disinhibited social engagement disorder are not accounted for by impulsivity, although socially disinhibited behavior is predominant. These patterns of disinhibited, developmentally inappropriate behaviors are presumed to be caused by pathogenic caregiving. Thus, for both reactive attachment disorder and disinhibited social engagement disorder, aberrant caretaking is presumed to be the predominant cause of the child's inappropriate behaviors. However, there have been cases of less severe disturbances in parenting that may also be associated with young children who exhibit some characteristics of reactive attachment disorder or disinhibited social engagement disorder. The DSM-5 criteria for reactive attachment disorder are described in Table 31.11a-1 and those for disinhibited social engagement disorder are described in Table 31.11a-2. Table 31.11a-1

DSM-5 Diagnostic Criteria for Reactive Attachment Disorder Table 31.11a-2 DSM-5 Diagnostic Criteria for Disinhibited Social Engagement Disorder These disorders may also result in a picture of failure to thrive, in which an infant shows physical signs of malnourishment and does not exhibit the expected developmental motor and verbal milestones.

EPIDEMIOLOGY Few data exist on the prevalence, sex ratio, or familial pattern of reactive attachment disorder and disinhibited social engagement disorder. It has been estimated for either one to occur in less than 1 percent of the population. A study of 1,646 children aged 6to 8-years-old living in a deprived sector of urban United Kingdom, found that the prevalence of reactive attachment disorder in this population was 1.4 percent. However, other studies of selected high-risk populations have estimated that about 10 percent of young children with documented neglectful and grossly pathological caregiving exhibit reactive attachment disorder, and up to 20 percent of children in this situation exhibit disinhibited social engagement disorder. In a retrospective report of children in one county of the United States who were removed from their homes because of neglect or abuse before the age of 4 years, 38 percent exhibited signs of either reactive attachment disorder or disinhibited social engagement disorder. Another study established the reliability of the diagnosis by reviewing videotaped assessments of atrisk children interacting with caregivers, along with a structured interview with caregivers. Given that pathogenic care, including maltreatment, occurs more frequently in the presence of general psychosocial risk factors, such as poverty, disrupted families, and mental illness among caregivers, these circumstances are likely to increase the risk of reactive attachment disorder and disinhibited social engagement disorder. ETIOLOGY The core features of reactive attachment disorder and disinhibited social engagement disorder are disturbances of normal attachment behaviors. The inability of a young child to develop normative social interactions that culminate in aberrant attachment behaviors in reactive attachment disorder is inherent in the disorder’s definition. Reactive attachment disorder and disinhibited social engagement disorder are presumed to be linked to maltreatment of the child, including emotional neglect, physical abuse, or both. Grossly pathogenic care of an infant or young child by the caregiver presumably causes the markedly disturbed social relatedness that is evident. The emphasis is on the unidirectional cause; that is, the caregiver does something inimical or neglects to do something essential for the infant or child. In evaluating a patient for whom such a diagnosis is appropriate, however, clinicians should consider the contributions of each member of the caregiver–child dyad and their interactions. Clinicians should weigh such things as infant or child temperament, deficient or defective bonding, a developmentally disabled child, and a particular caregiver–child mismatch. The likelihood of neglect increases with parental psychiatric disorder, substance abuse, intellectual disability, the parent’s own harsh upbringing, social isolation, deprivation, and premature parenthood (i.e. adolescent). These factors compromise parental ability to attend to the needs of the child, as they focus primarily on their own existence rather than on their child. Frequent changes of the primary caregivers, for example, from multiple foster care placements or repeated lengthy

hospitalizations, may also lead to impaired attachment. In the general population, a study of 1,600 children found that those children with reactive attachment disorder/disinhibited social engagement disorder showed a constellation of symptoms characterized by early emergence of symptoms eliciting neurodevelopmental examination (ESSENCE). Some of the associated symptoms in children with reactive attachment disorder/disinhibited social engagement disorder include higher risk of failure to gain weight as neonates, feeding difficulty, and poor impulse

control. These traits are likely to emerge because of both genetic and environmental factors. The authors found that children with reactive attachment disorder/disinhibited social engagement disorder were more likely to have multiple psychiatric comorbidities, lower intelligence quotients (IQs) compared to the general population, and more behavioral problems. Thus, a broad assessment may be necessary to identify symptoms and disorders associated with reactive attachment disorder/disinhibited social engagement disorder. DIAGNOSIS AND CLINICAL FEATURES Children with reactive attachment disorder and disinhibited social engagement disorder may initially be identified by a preschool teacher or by a pediatrician based on direct observation of the child's inappropriate social responses. The DSM-5 diagnostic criteria for reactive attachment disorder and disinhibited social engagement disorder are described in Tables 31.11a-1 and 31.11a-2, respectively. The diagnoses of reactive attachment disorder and disinhibited social engagement disorder are based partially on documented evidence of pervasive disturbance of attachment leading to inappropriate social behaviors present before the age of 5 years. The clinical picture varies greatly, depending on a child's chronological and mental ages, but expected social interaction and liveliness are not present. Often, the child is not progressing developmentally or is frankly malnourished. Perhaps the most common clinical picture of an infant with reactive attachment disorder is the nonorganic failure to thrive. Such infants usually exhibit hypokinesis, dullness, listlessness, and apathy, with a poverty of spontaneous activity. Infants look sad, joyless, and miserable. Some infants also appear frightened and watchful, with a radar-like gaze. Nevertheless, they may exhibit delayed responsiveness to a stimulus that would elicit fright or withdrawal from a normal infant. Infants with failure to thrive and reactive attachment disorder appear significantly malnourished, and many have protruding abdomens. Occasionally, foul-smelling, celiaclike stools are reported. In unusually severe cases, a clinical picture of marasmus appears. The infant's weight is often below the third percentile and markedly below the appropriate weight for his or her height. If serial weights are available, the weight percentiles may have decreased progressively because of an actual weight loss or a failure to gain weight as height increases. Head circumference is usually normal for the infant's age. Muscle tone may be poor. The skin may be colder and paler or more mottled than skin of a normal child. Laboratory findings may indicate coincident

malnutrition, dehydration, or concurrent illness. Bone age is usually retarded. Growth hormone levels are usually normal or elevated, a finding suggesting that growth failure in these children is secondary to caloric deprivation and malnutrition. Cortisol secretion in children with reactive attachment disorder or disinhibited social engagement disorder is lower than in typical developing children. For children with failure to thrive, improvement physically and weight gain generally occur rapidly after they are hospitalized. Socially, the infants with reactive attachment disorder usually show little spontaneous activity and a marked diminution of both initiative toward others and reciprocity in response to the caregiving adult or examiner. Both mother and infant may be indifferent to separation on hospitalization or to termination of subsequent hospital visits. The infants frequently show none of the normal upset, fretting, or protest about hospitalization. Older infants usually show little interest in their environment. They may not play with toys, even if encouraged; however, they rapidly or gradually take an interest in, and relate to, their caregivers in the hospital. Psychosocial δwarfism. Classic psychosocial dwarfism or psychosocially determined short stature is a syndrome that usually is first manifest in children 2 to 3 years of age. The children are typically unusually short and have frequent growth hormone abnormalities and severe behavioral disturbances. All of these symptoms result from an inimical caregiver–child relationship.

The affectionless character may appear when there is a failure, or lack of opportunity, to form attachments before the age of 2 to 3 years. Children cannot form lasting relationships, and their inability is sometimes accompanied by an inability to obey rules, a lack of guilt, and a need for attention and affection. Children with disinhibited social engagement disorder appear to be overly friendly and familiar with little fear. A 7-year-old boy was referred by his adoptive parents because of hyperactivity and inappropriate social behavior at school. He had been adopted at 4 years of age, after living most of his life in a Chinese orphanage in which he received care from a rotating shift of caregivers. Although he had been below the 5th percentile for height and weight on arrival, he quickly approached the 15th percentile in his new home. However, his adoptive parents were frustrated by his inability to bond with them. They had initially worried about an intellectual problem, although testing and his capacity to engage almost any adult and many children verbally suggested otherwise. He appeared to be too friendly, talking to anyone and often following strangers willingly. He showed little empathy when others were hurt and yet he would sit on the laps of teachers and students without asking. He was frequently injured because of seemingly reckless behavior, although he had an extremely high tolerance for pain. His parents focused on problem behaviors at home to decrease his impulsive behavior, which improved with much prompting; however, he remained oddly overfriendly at home and in school. The child was diagnosed with disinhibited social engagement

disorder. (Adapted from Neil W. Boris, M.D. and Charles H. Zeanah, Jr., M.D.) PATHOLOGY AND LABORATORY EXAMINATION Although no single specific laboratory test is used to make a diagnosis, many children with reactive attachment disorder have disturbances of growth and development. Thus, establishing a growth curve and examining the progression of developmental milestones may be helpful in determining whether associated phenomena, such as failure to thrive, are present. DIFFERENTIAL DIAGNOSIS The differential diagnosis of reactive attachment disorder and disinhibited social engagement disorder must take into account that many other psychiatric disorders may arise in conjunction with maltreatment, including depressive disorders, anxiety disorders, and posttraumatic stress disorders. Psychiatric disorders to consider in the differential diagnosis include language disorders, autism spectrum disorder, intellectual disability, and metabolic syndromes. Children with autism spectrum disorders are typically well nourished and of age-appropriate size and weight, and are generally alert and active, despite their impairments in reciprocal social interactions. Significant intellectual disability is often present in children with autism spectrum disorder, whereas when intellectual disability occurs with reactive attachment disorder or disinhibited social engagement disorder, it is generally relatively mild. Children with disinhibited social engagement disorder often show comorbid attentiondeficit/hyperactivity disorder, posttraumatic stress disorder, and language disorder or delay. Furthermore, children with disinhibited social engagement disorder symptoms may have complex neuropsychiatric problems. COURSE AND PROGNOSIS Most of the data available on the natural course of children with reactive attachment disorder and disinhibited social engagement disorder come from follow-up studies of children in residential facilities with histories of serious neglect. Findings from these studies suggest that children with reactive attachment disorder, who are later adopted into caring environments, improve in their attachment behaviors and may normalize over time. Children with disinhibited social engagement disorder, however, appear to have more difficulty developing attachments to new caregivers. Children with disinhibited social engagement disorder who exhibit indiscriminate social behavior also tend to have poor peer relationships. The prognosis for children with reactive attachment disorder and disinhibited social engagement disorder is influenced by the

duration and severity of the neglect and the degree of impairment that results. Constitutional and nutritional factors interact in children, who may either respond resiliently to treatment or continue to fail to thrive. After a pathological caregiving

situation has been recognized, the amount of treatment and rehabilitation that the family receives affects the child. Children who have multiple problems stemming from pathogenic caregiving may recover physically faster and more completely than they do emotionally. TREATMENT The first consideration in treating reactive attachment disorder or disinhibited social engagement disorder is a child's safety. Thus, the management of these disorders must begin with a comprehensive assessment of the current level of safety and adequate caregiving. When there is suspicion of maltreatment persisting in the home, the first decision is often whether to hospitalize the child or to attempt treatment while the child remains in the home. If neglect, or emotional, physical, or sexual abuse is suspected, legally, such must be reported to the appropriate law enforcement and child protective services in the area. The child's physical and emotional state and the level of pathological caregiving determine the therapeutic strategy. A determination must be made regarding the nutritional status of the child and the presence of ongoing physical abuse or threat. Hospitalization is necessary for children with malnourishment. Along with an assessment of the child's physical well-being, an evaluation of the child's emotional condition is important. Immediate intervention must address the parents' awareness and capacity to participate in altering the injurious patterns that have heretofore ensued. The treatment team must begin to improve the unsatisfactory relationship between caregiver and child. This usually requires extensive and intensive intervention and education with the mother or with both parents when possible. In one study, parents of 120 children between 11.7 months and 31.9 months, identified as being at risk for neglect, were randomly assigned to an intervention for atrisk parents called Attachment and Biobehavioral Catch-up (ABC) or to a control intervention. The ABC intervention was designed to decrease frightening behavior toward the infant by parents, and to increase sensitive and nurturing interactions between parents and infant. The intervention was manualized so that parents were specifically guided in how to provide those interactions with their infants. Children were evaluated after 10 sessions, and the 60 children who received the ABC intervention showed significantly lower rates of disorganized attachment (32%), and higher rates of secure attachment (52%) compared to those who received the control intervention (disorganized attachment 57%; secure attachment 33%). The authors concluded that parental nurturance and sensitivity can be enhanced by a comprehensive and explicit intervention such as the ABC intervention, and significant improvements in attachment behaviors can be measured in young children after 10 sessions. The caregiver–child relationship is the basis of the assessment of reactive attachment disorder and disinhibited social engagement disorder symptoms, and the substrate from which to modify attachment behaviors. Structured observations allow a clinician to determine the range of attachment behaviors established with various family members. The clinician may work closely with the caregiver and the child to facilitate greater

sensitivity in their interactions. Three basic psychotherapeutic modalities are helpful in promoting positive bonds between children and caregiver. First, a clinician can target the caregiver to promote positive interaction with a child who does not yet have the repertoire to respond positively. Second, a clinician can work with the child and the caregiver together as a dyad to advocate for practicing appropriate positive reinforcement for each other. Through the use of videotapes, parent–child interactions can then be viewed and modifications can be suggested to increase positive engagement. The third modality for clinical intervention is through individual work

with the child. Working with the child and caregiver together is often more effective in producing more emotionally meaningful exchanges than working with parent or child individually. Psychosocial interventions for families in which a child has reactive attachment disorder or disinhibited social engagement disorder include (1) psychosocial support services, including hiring a homemaker, improving the physical condition of the apartment, or obtaining more adequate housing; improving the family's financial status; and decreasing the family's isolation; (2) psychotherapeutic interventions, including individual psychotherapy, psychotropic medications, and family or marital therapy; (3) educational counseling services, including mother–infant or mother–toddler groups, and counseling to increase awareness and understanding of the child's needs and to develop parenting skills; and (4) provisions for close monitoring of the progression of the patient's emotional and physical well-being. Sometimes, separating a child from the stressful home environment temporarily, as in hospitalization, allows the child to break out of the accustomed pattern. A neutral setting, such as the hospital, is the best place to start with families who are genuinely available emotionally and physically for intervention. If interventions are unfeasible or inadequate or if they fail, placement with relatives or in foster care, adoption, or a group home or residential treatment facility must be considered. REFERENCES Bernard K, Dozier M, Carlson E, Bick J, Lewis-Morrarty, Lindheim O. Enhancing attachment organization among maltreated children: Results of a randomized clinical trial. Child Dev. 2012;83:623–636. Boris NW, Zeanah CH. Reactive attachment disorder of infancy, childhood and adolescence. In: BJ Sadock, VA Sadock, Ruiz P, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Vol. II. Philadelphia: Lippincott Williams & Wilkins; 2009:3636. Chaffin M, Hanson R, Saunders BE, Nichols T, Barnett D, Zeanah C, Berliner L, Egeland B, Newman E, Lyon T, LeTourneau E, Miller-Perrin C. Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. Child Maltreat. 2006;11:76. Heller SS, Boris NW, Fuselier SH, Pate T, Koren-Karie N, Miron D. Reactive attachment disorder in maltreated twins follow-up: From 18 months to 8 years. Attach Hum Dev. 2006;8:63. Kay C, Green J. Reactive attachment disorder following maltreatment: Systematic evidence beyond the institution. J Abnorm Child Psychol. 2013;41:571–581. Kocovska E, Puckering C, Follan M, Smillie M, Gorski C. Neurodevelopmental problems in maltreated children referred with indiscriminate friendliness. Res Dev Disabil. 2012;33:1560–1565.

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