RAD & DSED Over the Life Course: What do we know?

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Introduction

Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED) are socially disabling disorders. They are both caused by neglectful care in infancy and early life, usually including deprivation of attachment figures. Both RAD and DSED are arguably understudied in the psychiatric community. Most of the existing research into these disorders examines young children, while the developmental trajectory of RAD and DSED into adolescence and early adulthood remains poorly understood.

Two Distinct Disorders

RAD and DSED were previously thought to be two subtypes (inhibited and disinhibited) of Reactive Attachment Disorder. With the arrival of DSM-5, these two disorders were officially distinguished from one another. Although they share an etiology, they differ significantly in symptom manifestation, life course trajectory, and treatment.

REACTIVE ATTACHAMENT DISORDER is characterized by:

- Minimally seeking and/or responding to comfort
- Limited display of positive affect
- Minimal social/emotional responsiveness to others
- Unexplained irritability/sadness/fearfulness when interacting with caregivers

DISINHIBITED SOCIAL ENGAGEMENT DISORDER is characterized by:

- Limited restraint in approaching/interacting with unfamiliar adults
- Overly familiar interactions with unfamiliar people
- Socially disinhibited behaviour in unfamiliar settings
- Does not require a disordered attachment

Diagnostic challenges

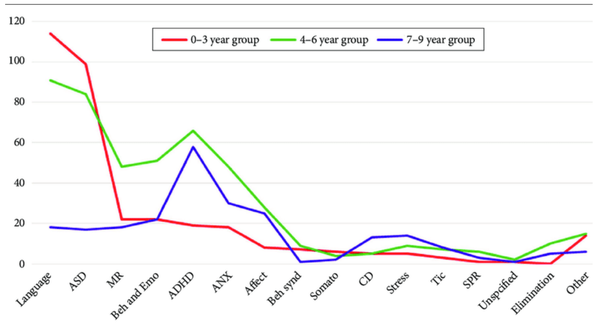
Diagnostic criteria for RAD and DSED were heavily influenced by research on children exposed to early severe institutional deprivation. Because of this, concerns remain about the effectiveness of the diagnostic criteria for children who have not experienced institutionalization. While there is consensus as to the criteria that must be met for a diagnosis, there is currently no gold standard for methods of assessment for RAD and DSED in children.

Comorbidity

Children with RAD and DSED often experience co-morbid challenges including:

A. Cognitive delays
B. Language delays
C. Stereotypies
D. RAD often associated with depression and conduct disorder
E. DSED often co-morbid with ADHD

The following graph depicts the distribution of psychiatric comorbidities by age group:



Language: developmental disorders of speech and language, ASD: autism spectrum disorder, MR: mental retardation, Beh and Emo: behavioral and emotional disorders, ADHD: attention deficit hyperactivity disorder, ANX: anxiety disorder, Affect: affective disorder, Beh synd: behavioral syndromes associated with physiological disturbances and physical factors, Somato: somatoform disorders, CD: conduct disorder, Stress: reaction to severe stress, and adjustment disorder, Tic: Tic disorder, SPR: schizophrenia, Unspecified: unspecified mental disorder, Elimination: Enuresis and Encopresis

(Hong et al., 2018)

Childhood

Both RAD and DSED stem from a failure to establish attachment in infancy and early life. This is often caused by extremely neglectful circumstances in which the child's physical and emotional needs are not met. RAD and DSED are most commonly seen in children under the age of 5. Many children diagnosed with RAD or DSED experience improvements when stable and nurturing care are acquired. However, RAD and DSED symptoms can persist into middle childhood. There is a lack of consensus about whether RAD and DSED symptoms in middle childhood are still purely attachment-related, or whether they should be considered PTSD. A glaring paucity of research in this area leaves this issue undetermined.

Adolescence

There is a dearth of research examining RAD and DSED beyond early childhood. Despite this, some research has recognized RAD and DSED as valid diagnostic constructs in adolescence, while others question whether symptoms of RAD and DSED in adolescence may be better conceptualized as more common psychiatric disorders.

Studies have recently focused on just this: the existence and appearance of RAD and DSED in adolescence (SEIM et al., 2020). Results show that both disorders remain distinct from one another and from other common psychiatric disorders through adolescence. Results from this research support the notion that RAD and DSED represent distinct diagnostic constructs in adolescence and are not better accounted for by other psychopathologies. Some notable differences were found in two symptom frequencies: **negative reunion responses (RAD)** and **minimal checking (DSED).** However, these differences in symptom presentation are believed to indicate the existence of age-typical symptoms of RAD and DSED.

Treatment

There is no standard treatment for either disorder. It is however imperative that prior to treatment beginning, the child have an emotionally available attachment figure. Treatment for both RAD and DSED will involve both the child and the caregiver. Treatments an include:

- Psychotherapy (child and/or caregiver)
- Play therapy
- Family therapy
- Parenting skills training
- Social skills intervention

Unanswered Questions

Due to the rare nature of both disorders, there is a real lack of research in this area examining developmental trajectories. Questions remain largely unanswered on many issues, including:

- What is the best way to assess for RAD and DSED at various stages of development?
- Do these disorders persist into adulthood?
- How does symptom manifestation change over the life course?
- Does treatment effectiveness change over time?

References

1. Hong et al. (2018). Incidence and Comorbidity of Reactive Attachment Disorder: Based on National Health Insurance Claims Data, 2010-2012 in Korea. Psychiatry investigation.

2.Nelson et al. (2020). Can reactive attachment disorder persist in nurturing placements? A systematic review and clinical case series. Developmental Child Welfare. 2. 110-131.

3.Seim, A., Jozefiak, T., Wichstrøm, L., & Kayed, N. (2020). Validity of reactive attachment disorder and disinhibited social engagement disorder in adolescence. European Child & Adolescent Psychiatry, 29(10), 1465–1476.

4.Zajac, K., Randall, J., & Swenson, C. (2015). Multisystemic Therapy for Externalizing Youth. Child and Adolescent Psychiatric Clinics of North America, 24(3), 601–616.

5.Zeanah, C., Chesher, T., Boris, N., Walter, H., Bukstein, O., Bellonci, C., … Stock, S. (2016). Practice Parameter for the Assessment and Treatment of Children and Adolescents With Reactive Attachment Disorder and Disinhibited Social Engagement Disorder. Journal of the American Academy of Child & Adolescent Psychiatry, 55(11), 990–1003.

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