Reactive attachment/disinhibited social engagement disorders: Callous-unemotional traits and comorbid disorders

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A R T I C L E   H I S T O R Y
Article history:
Received 16 September 2016
Received in revised form 16 February 2017
Accepted 20 February 2017
Number of reviews completed is 2

K e y w o r d s:
Reactive attachment disorder
Disinhibited social engagement disorder
Callous-unemotional traits
Conduct disorder
Comorbidity

A B S T R A C T

Background: DSM-5 Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED) are rare, understudied, and controversial disorders.

Methods: Comorbidity in children diagnosed with RAD or DSED was compared with comorbidity in ADHD and autism to determine if RAD/DSED comorbidity differed from that for the two most common disorders in child psychiatric clinics. Samples included 4–17-year-olds, 20 with RAD and/or DSED, 933 with autism, and 895 with ADHD. Children with RAD/DSED were removed from their neglectful environments at a mean of 4 years and were a mean 10 years when studied. Mothers rated the children on the Pediatric Behavior Scale assessing oppositional behavior, conduct problems, ADHD, anxiety, depression, and other symptoms.

Results: Five of the 20 children with RAD/DSED had DSED without RAD, 15 had RAD with DSED, and none had RAD without DSED. All children with RAD had callous-unemotional traits (CU) and 73% had conduct disorder (CD). No children with DSED-no RAD had CU or CD. Children with RAD + DSED were considerably more impaired than children with DSED-no RAD, autism, and ADHD.

Conclusions: Findings are consistent with other studies indicating high CD/CU comorbidity in RAD and extreme rarity of RAD without DSED, findings which are not noted in the DSM-5.

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What this paper adds

Reactive Attachment Disorder (RAD) is an understudied and controversial topic and much needs to be learned about comorbidity in RAD and the newly introduced DSM-5 diagnosis of Disinhibited Social Engagement Disorder (DSED). Knowledge gaps include determining comorbidity in RAD and DSED, if RAD can persist in children years after removal from their neglectful environments, the degree to which RAD and DSED co-occur, and correspondence between RAD and DSED and DSM-IV inhibited and disinhibited RAD. There is considerable debate in the literature regarding the answers to these questions. Our study found that (1) not all children recover from RAD, even after having been removed from their neglectful environments a mean of 6 years earlier, (2) children with RAD or DSED had a mean of four additional diagnoses, including ADHD, oppositional defiant disorder, autism, conduct disorder (CD), depression, anxiety disorder, and posttraumatic stress disorder, (3) children with RAD were more impaired than children with DSED, autism, and ADHD, (4) all children with RAD...
displayed callous-unemotional (CU) traits (but not all had CD), and none of the children with DSED without RAD had CU traits or CD. (5) all children in our study meeting DSM-5 RAD criteria also met DSM-5 DSED criteria (i.e., RAD did not occur without DSED, but DSED could occur without RAD), and (6) all children with DSM-5 RAD also met criteria for DSM-IV RAD inhibited type and all children with DSM-5 DSED met DSM-IV RAD disinhibited type criteria. These findings have implications for the DSM and ICD.

1. Introduction

Reactive Attachment Disorder (RAD) in the DSM-IV was divided into two disorders in the DSM-5: RAD and Disinhibited Social Engagement Disorder (DSED). DSM-5 RAD was formerly DSM-IV RAD Inhibited Type and is RAD in the International Classification of Diseases (ICD)-10. DSM-5 DSED was referred to as RAD Disinhibited Type in the DSM-IV and is Disinhibited Attachment Disorder in the ICD-10.

Inhibited and disinhibited RAD comprise a pattern of abnormal behaviors in children who have been maltreated or have not had the opportunity to form selective attachments (Boris, Zeanah, & The Work Group on Quality Issues, 2005). A diagnostic requirement for both DSM-5 RAD and DSED is “social neglect” and “absence of adequate caregiving during childhood” (p. 265). According to the DSM-5, the etiology for both RAD and DSED is early social and emotional neglect. However, symptoms differ between the two types of disorders. DSM-5 RAD criteria are the child rarely seeks and responds to caregiver comfort, support, nurturance, or protection when distressed and the child exhibits at least two of the following three symptoms: minimal social-emotional responsiveness to others, limited positive affect, and episodes of unexplained irritability, sadness, or fearfulness. DSED symptom criteria are at least two of the following: approaches and interacts with unfamiliar adults, overly familiar behavior, diminished checking back with caregiver, and willingness to go off with an unfamiliar adult.

RAD and DSED are exceedingly rare disorders (Zeanah & Gleason, 2010), which has made researching these conditions challenging. In fact, RAD/DSED cases were absent or too few to analyze in the DSM-5 field trials (Regier et al., 2013). In a population-based sample of 1646 low socioeconomic urban children in the United Kingdom, 6–8 years of age, the prevalence of RAD was only 1.4% (Minnis et al., 2013). Additionally, empirical publications are scarce (Boris et al., 2005; Capelletty, Brown, & Shumate, 2005; Zeanah & Gleason, 2010), research sample sizes are small, little is known about school age children with RAD (Follan et al., 2011), and evidence-based diagnostic and treatment studies are sorely lacking (Capelletty et al., 2005; Kay & Green, 2012).

The early work of John Bowlby has been greatly influential. In a monograph prepared for the World Health Organization, Bowlby (1951) reviewed three studies and concluded that maternal deprivation (i.e., lack of an opportunity to form an attachment to a mother–figure during the first 3 years of life, maternal deprivation for more than 6 months, or changes from one mother–figure to another during the first 3 or 4 years of life) could produce the “affectionless psychopath” (i.e., an antisocial person who is unable to form stable relationships with others). Hall and Geher (2003) reviewed articles and books published in the 1980s and 1990s which described common comorbid problems in RAD including lying, stealing, destruction of property, cruelty to animals and people, absence of conscience and remorse, and criminal behavior in adulthood.

Recent studies demonstrate a significant relationship between attachment problems and psychopathology and behavior problems (Elavainio, Raaska, Sinkkonen, Makipaa, & Lapinleimu, 2015; Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsey, & Roisman, 2010; Green & Goldwyn, 2002; Green, Stanley, & Peters, 2007; Greenberg, Spitzel, & DeKlyen, 1993), as well as between maltreatment and psychopathology and conduct problems (McDonald, Milne, Knight, & Webster, 2013; Norman et al., 2012; Oswald, Heil, & Goldbeck, 2010). Relatedly, callous-unemotional (CU) traits are associated with maltreatment and neglect (Humphreys et al., 2015; Kimonis, Cross, Howard, & Donoghue, 2013) and attachment problems (Pascalich, Dadds, Hawes, & Brennan, 2012). CU traits are referred to as limited prosocial emotions in the DSM-5 with symptoms including shallow affect; lack of remorse, guilt, and empathy; and being unconcerned about performance in developmentally important activities.

Research demonstrates considerable diagnostic comorbidity in RAD including conduct disorder (CD), oppositional defiant disorder (ODD), attention deficit hyperactivity disorder (ADHD), autism, posttraumatic stress disorder (PTSD), anxiety disorders, and depression (Davidson et al., 2015; Gleason et al., 2011; Hall & Geher, 2003; Minnis et al., 2009, 2013; O’Connor, Bredenkamp, & Rutter, 1999; Pritchett, Pritchett, Marshall, Davidson, & Minnis, 2013). Strikingly, the DSM-5 does not mention any of these disorders in its discussion of RAD/DSED comorbidity and, instead, notes other comorbid problems (e.g., cognitive and language delays and stereotypies) that have not necessarily been supported by research in older children (Mayes, Calhoun, Waschbusch, Lockridge, & Bawea, 2016; O’Connor et al., 1999). Unlike the DSM-5, the ICD-10 notes that emotional and behavior disturbances are associated with RAD. As stated by Hall and Geher (2003), “behavioral problems...are clearly the main concerns of caregivers of children with RAD. Furthermore, these behavioral problems are most relevant throughout the lives of children with RAD. Because both behaviors and attachment patterns are integral to the diagnosis of RAD, it may be most appropriate for researchers to address the behavioral difficulties of these children and for diagnostic criteria to include identified common behaviors in addition to an exploration of attachment patterns” (p. 147).

In contrast, others argue that a diagnosis of RAD is not warranted when comorbid problems, particularly conduct problems (CD or ODD) are present. For example, Woolgar and Balduck (2015) reported that, in their study of 31 children who were “identified with either attachment disorder or attachment problems” by community agencies and professionals (p. 37), only three were diagnosed with RAD in an adoption and fostering specialty clinic. In contrast, 18 were diagnosed with ODD or CD and 11 with ADHD.
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