tic spectrum disorder exhibit selective impairments in social communicative behaviors, such as intentional communication (i.e., impairment in communication that is deliberate, goal-directed, and aimed at influencing the behavior of the recipient). Children with reactive attachment disorder show social communicative functioning comparable to their overall level of intellectual functioning. Finally, children with autistic spectrum disorder regularly show attachment behavior typical for their developmental level. In contrast, children with reactive attachment disorder do so only rarely or inconsistently, if at all.

**Intellectual disability (intellectual developmental disorder).** Developmental delays often accompany reactive attachment disorder, but they should not be confused with the disorder. Children with intellectual disability should exhibit social and emotional skills comparable to their cognitive skills and do not demonstrate the profound reduction in positive affect and emotion regulation difficulties evident in children with reactive attachment disorder. In addition, developmentally delayed children who have reached a cognitive age of 7–9 months should demonstrate selective attachments regardless of their chronological age. In contrast, children with reactive attachment disorder show lack of preferred attachment despite having attained a developmental age of at least 9 months.

**Depressive disorders.** Depression in young children is also associated with reductions in positive affect. There is limited evidence, however, to suggest that children with depressive disorders have impairments in attachment. That is, young children who have been diagnosed with depressive disorders still should seek and respond to comforting efforts by caregivers.

## Comorbidity

Conditions associated with neglect, including cognitive delays, language delays, and stereotypies, often co-occur with reactive attachment disorder. Medical conditions, such as severe malnutrition, may accompany signs of the disorder. Depressive symptoms also may co-occur with reactive attachment disorder.

# Disinhibited Social Engagement Disorder

## Diagnostic Criteria **313.89 (F94.2)**

A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:
   1. Reduced or absent reticence in approaching and interacting with unfamiliar adults.
   2. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
   3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
   4. Willingness to go off with an unfamiliar adult with minimal or no hesitation.

B. The behaviors in Criterion A are not limited to impulsivity (as in attention-deficit/hyperactivity disorder) but include socially disinhibited behavior.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
   1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
   2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
   3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).
E. The child has a developmental age of at least 9 months.

*Specify* if:

**Persistent:** The disorder has been present for more than 12 months.

*Specify* current severity:

Disinhibited social engagement disorder is specified as **severe** when the child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

## Diagnostic Features

The essential feature of disinhibited social engagement disorder is a pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers (Criterion A). This overly familiar behavior violates the social boundaries of the culture. A diagnosis of disinhibited social engagement disorder should not be made before children are developmentally able to form selective attachments. For this reason, the child must have a developmental age of at least 9 months.

## Associated Features Supporting Diagnosis

Because of the shared etiological association with social neglect, disinhibited social engagement disorder may co-occur with developmental delays, especially cognitive and language delays, stereotypies, and other signs of severe neglect, such as malnutrition or poor care. However, signs of the disorder often persist even after these other signs of neglect are no longer present. Therefore, it is not uncommon for children with the disorder to present with no current signs of neglect. Moreover, the condition can present in children who show no signs of disordered attachment. Thus, disinhibited social engagement disorder may be seen in children with a history of neglect who lack attachments or whose attachments to their caregivers range from disturbed to secure.

## Prevalence

The prevalence of disinhibited social attachment disorder is unknown. Nevertheless, the disorder appears to be rare, occurring in a minority of children, even those who have been severely neglected and subsequently placed in foster care or raised in institutions. In such high-risk populations, the condition occurs in only about 20% of children. The condition is seen rarely in other clinical settings.

## Development and Course

Conditions of social neglect are often present in the first months of life in children diagnosed with disinhibited social engagement disorder, even before the disorder is diagnosed. However, there is no evidence that neglect beginning after age 2 years is associated with manifestations of the disorder. If neglect occurs early and signs of the disorder appear, clinical features of the disorder are moderately stable over time, particularly if conditions of neglect persist. Indiscriminate social behavior and lack of reticence with unfamiliar adults in toddlerhood are accompanied by attention-seeking behaviors in preschoolers. When the disorder persists into middle childhood, clinical features manifest as verbal and physical overfamiliarity as well as inauthentic expression of emotions. These signs appear particularly apparent when the child interacts with adults. Peer relationships are most affected in adolescence, with both indiscriminate behavior and conflicts apparent. The disorder has not been described in adults.

Disinhibited social engagement disorder has been described from the second year of life through adolescence. There are some differences in manifestations of the disorder from early childhood through adolescence. At the youngest ages, across many cultures, children show reticence when interacting with strangers. Young children with the disorder fail to show reticence to approach, engage with, and even accompany adults. In preschool children, verbal and social intrusiveness appear most prominent, often accompanied by attention-seeking behavior. Verbal and physical overfamiliarity continue through middle childhood, accompanied by inauthentic expressions of emotion. In adolescence, indiscriminate behavior extends to peers. Relative to healthy adolescents, adolescents with the disorder have more "superficial" peer relationships and more peer conflicts. Adult manifestations of the disorder are unknown.

## Risk and Prognostic Factors

**Environmental.** Serious social neglect is a diagnostic requirement for disinhibited social engagement disorder and is also the only known risk factor for the disorder. However, the majority of severely neglected children do not develop the disorder. Neurobiological vulnerability may differentiate neglected children who do and do not develop the disorder. However, no clear link with any specific neurobiological factors has been established. The disorder has not been identified in children who experience social neglect only after age 2 years. Prognosis is only modestly associated with quality of the caregiving environment following serious neglect. In many cases, the disorder persists, even in children whose caregiving environment becomes markedly improved.

**Course modifiers.** Caregiving quality seems to moderate the course of disinhibited social engagement disorder. Nevertheless, even after placement in normative caregiving environments, some children show persistent signs of the disorder, at least through adolescence.

## Functional Consequences of Disinhibited Social Engagement Disorder

Disinhibited social engagement disorder significantly impairs young children's abilities to relate interpersonally to adults and peers.

## Differential Diagnosis

**Attention-deficit/hyperactivity disorder.** Because of social impulsivity that sometimes accompanies attention-deficit/hyperactivity disorder (ADHD), it is necessary to differentiate the two disorders. Children with disinhibited social engagement disorder may be distinguished from those with ADHD because the former do not show difficulties with attention or hyperactivity.

## Comorbidity

Limited research has examined the issue of disorders comorbid with disinhibited social engagement disorder. Conditions associated with neglect, including cognitive delays, language delays, and stereotypies, may co-occur with disinhibited social engagement disorder. In addition, children may be diagnosed with ADHD and disinhibited social engagement disorder concurrently.

# Posttraumatic Stress Disorder

## Diagnostic Criteria **309.81 (F43.10)**

### Posttraumatic Stress Disorder

**Note:** The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

   **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

   **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

   **Note:** In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

   **Note:** In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

*Specify* whether:

**With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

**Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

*Specify* if:

**With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

## Posttraumatic Stress Disorder for Children 6 Years and Younger

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.