

Trauma- and Stressor-Related Disorders

Trauma- and stressor-related disorders include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion. These include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders. Placement of this chapter reflects the close relationship between these diagnoses and disorders in the surrounding chapters on anxiety disorders, obsessive-compulsive and related disorders, and dissociative disorders.

Psychological distress following exposure to a traumatic or stressful event is quite variable. In some cases, symptoms can be well understood within an anxiety- or fear-based context. It is clear, however, that many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety- or fear-based symptoms, the most prominent clinical characteristics are anhedonic and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms. Because of these variable expressions of clinical distress following exposure to catastrophic or aversive events, the aforementioned disorders have been grouped under a separate category: *trauma- and stressor-related disorders*. Furthermore, it is not uncommon for the clinical picture to include some combination of the above symptoms (with or without anxiety- or fear-based symptoms). Such a heterogeneous picture has long been recognized in adjustment disorders, as well. Social neglect—that is, the absence of adequate caregiving during childhood—is a diagnostic requirement of both reactive attachment disorder and disinhibited social engagement disorder. Although the two disorders share a common etiology, the former is expressed as an internalizing disorder with depressive symptoms and withdrawn behavior, while the latter is marked by disinhibition and externalizing behavior.

Reactive Attachment Disorder

Diagnostic Criteria

313.89 (F94.1)

- A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
 - 1. The child rarely or minimally seeks comfort when distressed.
 - 2. The child rarely or minimally responds to comfort when distressed.
- B. A persistent social and emotional disturbance characterized by at least two of the following:
 - 1. Minimal social and emotional responsiveness to others.
 - 2. Limited positive affect.
 - 3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.
- 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 lack of adequate care in Criterion C).
- E. The criteria are not met for autism spectrum disorder.
- F. The disturbance is evident before age 5 years.
- G. 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:

Reactive attachment disorder is specified as **severe** when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Diagnostic Features

Reactive attachment disorder of infancy or early childhood is characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance. The essential feature is absent or grossly underdeveloped attachment between the child and putative caregiving adults. Children with reactive attachment disorder are believed to have the capacity to form selective attachments. However, because of limited opportunities during early development, they fail to show the behavioral manifestations of selective attachments. That is, when distressed, they show no consistent effort to obtain comfort, support, nurturance, or protection from caregivers. Furthermore, when distressed, children with this disorder do not respond more than minimally to comforting efforts of caregivers. Thus, the disorder is associated with the absence of expected comfort seeking and response to comforting behaviors. As such, children with reactive attachment disorder show diminished or absent expression of positive emotions during routine interactions with caregivers. In addition, their emotion regulation capacity is compromised, and they display episodes of negative emotions of fear, sadness, or irritability that are not readily explained. A diagnosis of reactive attachment disorder should not be made in children who are developmentally unable 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, reactive attachment disorder often co-occurs with developmental delays, especially in delays in cognition and language. Other associated features include stereotypies and other signs of severe neglect (e.g., malnutrition or signs of poor care).

Prevalence

The prevalence of reactive attachment disorder is unknown, but the disorder is seen relatively rarely in clinical settings. The disorder has been found in young children exposed to severe neglect before being placed in foster care or raised in institutions. However, even in populations of severely neglected children, the disorder is uncommon, occurring in less than 10% of such children.

Development and Course

Conditions of social neglect are often present in the first months of life in children diagnosed with reactive attachment disorder, even before the disorder is diagnosed. The clinical features of the disorder manifest in a similar fashion between the ages of 9 months and 5 years. That is, signs of absent-to-minimal attachment behaviors and associated emotionally aberrant behaviors are evident in children throughout this age range, although differing cognitive and motor abilities may affect how these behaviors are expressed. Without remediation and recovery through normative caregiving environments, it appears that signs of the disorder may persist, at least for several years.

It is unclear whether reactive attachment disorder occurs in older children and, if so, how it differs from its presentation in young children. Because of this, the diagnosis should be made with caution in children older than 5 years.

Risk and Prognostic Factors

Environmental. Serious social neglect is a diagnostic requirement for reactive attachment disorder and is also the only known risk factor for the disorder. However, the majority of severely neglected children do not develop the disorder. Prognosis appears to depend on the quality of the caregiving environment following serious neglect.

Culture-Related Diagnostic Issues

Similar attachment behaviors have been described in young children in many different cultures around the world. However, caution should be exercised in making the diagnosis of reactive attachment disorder in cultures in which attachment has not been studied.

Functional Consequences of Reactive Attachment Disorder

Reactive attachment disorder significantly impairs young children's abilities to relate interpersonally to adults or peers and is associated with functional impairment across many domains of early childhood.

Differential Diagnosis

Autism spectrum disorder. Aberrant social behaviors manifest in young children with reactive attachment disorder, but they also are key features of autism spectrum disorder. Specifically, young children with either condition can manifest dampened expression of positive emotions, cognitive and language delays, and impairments in social reciprocity. As a result, reactive attachment disorder must be differentiated from autism spectrum disorder. These two disorders can be distinguished based on differential histories of neglect and on the presence of restricted interests or ritualized behaviors, specific deficit in social communication, and selective attachment behaviors. Children with reactive attachment disorder have experienced a history of severe social neglect, although it is not always possible to obtain detailed histories about the precise nature of their experiences, especially in initial evaluations. Children with autistic spectrum disorder will only rarely have a history of social neglect. The restricted interests and repetitive behaviors characteristic of autism spectrum disorder are not a feature of reactive attachment disorder. These clinical features manifest as excessive adherence to rituals and routines; restricted, fixated interests; and unusual sensory reactions. However, it is important to note that children with either condition can exhibit stereotypic behaviors such as rocking or flapping. Children with either disorder also may exhibit a range of intellectual functioning, but only children with autism

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.