# Reactive Attachment Disorder and Disinhibited Social Engagement Disorder

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**Dates Reviewed: 05/13, 05/14, 05/15, 07/16, 07/17, 07/18, 07/19, 09/20, 9/2021, 10/2022, 10/2023**

**Developed By:** Medical Necessity Criteria Committee

## I. Description

Reactive Attachment Disorder of Infancy or Early Childhood (RAD) and Disinhibited Social Engagement Disorder (DSED) are characterized by markedly disturbed and developmentally inappropriate ways of relating socially in most contexts. RAD takes the form of a persistent failure to initiate or respond to most social interactions in a developmentally appropriate way, while DSED presents as indiscriminate sociability, such as excessive familiarity with relative strangers. Required for either diagnosis is a severely adverse early caregiving environment. Children with reactive attachment disorder have no positive attachment to any adult. Children with DSED may have no attachment, an aberrant attachment, or a positive attachment.

The following criteria are intended as a guide for establishing medical necessity for the requested level of care. They are not a substitute for clinical judgment and should be applied by appropriately trained clinicians giving consideration to the unique circumstances of each patient, including co-morbidities, safety and supportiveness of the patient's environment, and the unique needs and vulnerabilities of children and adolescents.

**Diagnosis:** Appropriate diagnosis is made according to diagnostic criteria in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*

**Assessment & Treatment Notes:**

- Assessment for RAD or DSED requires evidence directly obtained from serial observations of the child interacting with his/her primary caregivers and with unfamiliar adults, as well as careful review of history (if available). Typically, a full assessment takes 2-3 sessions.
- After assessment, any suspicion of previously unreported or current maltreatment requires reporting to the appropriate protective services agency.
- Assessment of the caregiver's attitudes toward and perceptions about the child should be addressed in the child's treatment plan.

- The diagnosis of RAD or DSED should be ruled out in any case where there is no evidence of parental neglect, abuse, or repeated changes in primary caregiving.

- The core intervention for young children with RAD or DSED is ensuring they have a stable, safe environment with an emotionally available attachment figure.

- Children that are so aggressive as to be unmanageable in the family setting may require referral for a higher level of care.

- Therapeutic intervention should focus on supporting the caregiver in providing the attachment relationship. This may be done through individual work with the caregiver and/or dyadic work with the caregiver and child. Individual therapy should only be considered as a limited, adjunctive service for dealing with behaviors that interfere with dyadic therapy.

- Co-occurring disruptive behavior disorders (Conduct Disorder, ODD) should be addressed separately in the treatment plan with appropriate treatment interventions.

**Exclusions:**

The following modalities have no empirical support, have been associated with serious harm including death, and are specifically excluded:

1. Interventions that promote regression for "reattachment. "
2. Interventions designed to enhance attachment which involve physical restraint or coercion, including (but not limited to):
    a. therapeutic holding
    b. compression holding
    c. "reworking" of trauma
    d. rebirthing therapy

## II. Criteria: CWQI BHC-0010

A. **Continued authorization:**

Continued authorization is indicated by **ALL** of the following:

1. The treatment plan establishes achievable recovery goals appropriate to the patient's symptoms, resources, and functioning.
2. Treatment is provided at the lowest level of intensity (including frequency and duration of outpatient sessions and duration of the treatment episode) necessary to maintain the patient's stability and achieve progress toward appropriate treatment goals.
3. The treatment plan includes a realistic plan for termination and promotes the patient's ability to independently manage symptoms and resolve problems.

Plus **1 or more** of the following:

4. Continued measurable improvement in symptoms and/or functioning as evidenced by improvement in behavioral outcome measures.
5. Continued progress toward development of skills to prevent relapse.

6. Treatment plan revision to address lack of progress. If no improvement is noted, the treatment plan should be modified to include the consideration of
    a. Need for medication evaluation
    b. Need for psychosocial interventions (e.g., support groups)
    c. Possibility of co-occurring conditions that need attention including co-occurring medical or behavioral health conditions
7. If there is a demonstrated risk of deterioration with no further treatment, appropriate maintenance treatment is covered. If continued treatment is intended primarily to prevent deterioration, and significant improvement in symptoms is not expected, treatment should be provided at the least intensive level required to prevent deterioration.

***Note**: Authorization for treatment will be based upon reasonable goals and expectations, and with the **explicit inclusion of caregiver participation in treatment**. Prognosis for optimal functioning, which should be continually assessed, varies depending on a number of factors; however, access to an emotionally available attachment figure is critical for treatment to proceed.*

B. **Termination criteria:**

Termination of continued authorization is indicated by **1 or more** of the following:

1. Caregiver is able to consistently provide an environment for socially appropriate interactions without the need for ongoing psychotherapy support.
2. Patient is not improving, despite amendments to the treatment plan (consider referral to another therapist or another form of treatment).
3. Patient has achieved a stable level of functioning and further treatment is not expected to produce significant improvement.

## III. Information Required with the Prior Authorization Request:

1. Diagnosis and presenting symptoms
2. Relevant psycho-social and treatment history
3. Assessment of both substance abuse and mental health concerns
4. Measurable treatment goals
5. Scope and duration of planned treatment interventions
6. Response to treatment, including measurable change in symptom presentation, outcomes measures used, and results of outcomes measures
7. Medical conditions affecting treatment and coordination with medical providers

## IV. Annual Review History

| Review Date | Revisions | Effective Date |
|---|---|---|
| 05/2013 | Annual Review. Added table with review date, revisions, and effective date. Minor wording changes, removed reference to the DSM-IV and changed to current edition. | 05/2013 |
| 05/2014 | Annual Review. | 05/2014 |
| 05/2015 | Annual Review. Clarification in Subject line. | 05/2015 |
| 07/2016 | Annual Review. | 07/2016 |
| 07/2017 | Annual Review. | 08/2017 |
| 07/2018 | Annual Review. | 08/2018 |
| 07/2019 | Added clarification re: role of and application of criteria; removed statement that appeared to limit scope of treatment; additional minor clarifications. | 09/2019 |
| 09/2020 | Annual Review: No changes | 10/2020 |
| 9/2021 | Changed title and updated diagnostic information (added DSED). Updated references. Updated recommended therapeutic interventions. | 10/2021 |
| 10/2022 | Annual Review. No substantive changes. | 11/2022 |
| 10/2023 | Annual review. Removed sentence fragment that did not belong. | 11/2023 |

## V. References


1. American Academy of Child & Adolescent Psychiatry (2016). Policy statement: Coercive interventions for reactive attachment disorder. Child Abuse and neglect Committee. Accessed 8/27/21 at aacap.org/AACAP/PolicyStatements/Home.aspx
2. American Academy of Child & Adolescent Psychiatry (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
3. American Psychiatric Association (2002). Position statement: Reactive attachment disorder. Washington, DC: American Psychiatric Association.
4. Schuengel Carlo, Oosterman Mirjam and Sterkenburgh Paula. (2009). Children with disrupted attachment histories: Interventions and psychophysiological indices of effects. *Child and Adolescent Psychiatry and Mental Health,* 3(26). Available online at http://www.biomedcentral.com/.
5. Speltz, ML. (2002). Description, history, and critique of corrective attachment therapy. The APSAC Advisor, 14(3): 4-8.