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Case Report

Diagnostic Complexities in An Adolescent with Disinhibited Social Engagement Disorder (DSED)

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Abstract

Objective

Attachment disorders include Disinhibited Social Engagement Disorder (DSED) which occurs due to social neglect and a lack of consistent caregiver. DSED presents with overly social behaviour and shallow superficial relationships. Methods: We report an 11-year-old girl who was the victim of 2 sexual assaults. She appeared to be indiscriminately friendly with strangers and had a history of disordered attachment. Results: A retrospective diagnosis of DSED was made despite her age. She was planned for targeted behavioural therapy with a child unit, but the parents' defaulted treatment.

Conclusion: Mental health workers should be trained to diagnose DSED in older children in rare situations such as this.

Keywords: Disinhibited Social Engagement Disorder; Attachment; Adolescent

Introduction

Attachment is an essential component to social and emotional development of children [1,2]. Attachment theories study human bonding behaviour, specifically between a child and their primary caregiver [1,3]. Bowlby's attachment theory initially addressed infants but is now being expanded to address attachments in adolescents [1,4]. Attachments in adolescents are assessed differently, focusing on their ability to have healthy social relationships [1]. Reactive Attachment Disorder (RAD) describes severe behavioural disturbances in children stemming from a failure of attachment in infancy [4,6]. RAD had 2 possible clinical spectrums; the inhibited picture or the disinhibited one. Simply put, RAD is the child 'reacting' to pathological caregiving [4]. DSM 5 further divides RAD into 2 distinct disorders: RAD for inhibited, withdrawn behaviour and Disinhibited Social Engagement Disorder (DSED) which displayed the opposite [5]. They are categorised as trauma related disorders.

DSED, oversimplified as "indiscriminate friendliness", presents with overly social behaviour and shallow superficial relationships [5-9]. This is due to social neglect and a lack of a consistent attachment figure in the first 2 years of life [6]. DSED has a varying spectrum of violating social norms. The danger to the child is significant, as they are vulnerable to abuse and exploitation, particularly as sexual "acting out" occurs precociously [4,8]. These diagnoses were almost always made in young children, but are increasingly being recognised in adolescents [2,4]. Adolescence in itself is a trying time as attachment becomes complicated, involving external influences [9].

Case Report

M is an 11-year-old Murut girl who was referred to psychiatric services from the paediatric ward after being a victim of a sexual assault. This is her first contact with a psychiatrist. M was allegedly raped by an adult male whom she contacted and communicated with via social media 4 days prior to admission. She met him after school and consented to having sexual intercourse with him. M confided in her older brother days later and he subsequently lodged a police report. This is alarming as there was an identical

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incident a year ago, where M met two adult men via the same site and was raped. Months after the incident, a friend at school alerted the counsellor and the police and parents were informed. M insisted that it was her choice to be sexually active with these men, but due to her age, they were arrested, and the investigation is ongoing. M denied being pressured to meet these men but enjoyed their company. She also admits to having an 18-year-old boyfriend, whom she met online a year ago and is sexually active with.

M currently denies any depressive symptomatology and categorically denies harbouring any suicidal thoughts. Her appetite and sleep remain undisturbed and she is observed to be cheerful in the ward and friendly with staff and other patients. M appears aloof and detached from her mother and is rarely seen communicating with her. M denied any psychotic symptoms and there was no grossly abnormal behaviour observed in the ward. M began self-cutting at the age of 9, when she was angry with her father for reprimanding her. The cutting was a way of relieving her "tension" and anger at her parents. M frequently cuts her forearms and finds it cathartic. M denies being touched inappropriately in the past or being harmed by her parents or any family members. M started watching pornographic videos at the age of 9 on her fathers' phone after she found them by accident. When asked about her early childhood, M was unable to recall any happy memories with her parents.

Her mother corroborated that she has been smoking for more than a year, and usually accepts cigarettes from strangers she meets around her residential area. Her mother caught her inhaling gum a year ago, but M denies any other substance abuse. M's mother also noted that she steals small amounts of money left at home but admits M took the money for school projects. M has been left largely unsupervised as her 2 older siblings are busy in college and her parents work long hours. At times, M may not have any communication with a family member for days. Her father works in Pahang and is rarely home while her mother works long shifts in a hotel and is usually home after M is asleep. She buys food for M and leaves it on the table. M walks to and from school alone daily, and over the past 3 years, admits to sometimes playing truant as she's "bored". There have been no other disciplinary issues at school and she is a cheerful, respectful girl. Her academic performance is average, and she enjoys Mathematics. There is no history of her bullying other children, getting into altercations or cruelty to animals.

M was an unplanned pregnancy and her mother only discovered the pregnancy in the 3rd trimester. It was an unbooked pregnancy, but M was delivered uneventfully. M had a series of babysitters, and this frequently rotated, as her parents were unable to afford the more established centres. M's grandmother offered to care for her but due to a family conflict, M's mother refused. M's maternal grandmother had cared for her 2 older siblings and appeared to be consistent in their lives. According to her mother, M was a "difficult" baby and was hard to manage. M's mother usually left her in the care of various babysitters throughout the week. She was unable to recall any gross developmental delays.

M's parents informed the welfare department that they were unable to care for her after the first rape in 2017, and she was sent to a group home run by the welfare department. Due to a complaint lodged by the parents after 6 months regarding the poor condition of the home, M was released into their care in September 2017.

Physical examination revealed multiple, superficial scars over each forearm but no evidence of old bruises, scars or fractures. The vaginal examination was consistent with the history provided. Screening for sexually transmitted diseases were done and were negative.

M's father was unable to meet with the managing team despite multiple phone calls. Her mother agreed to therapy under our psychiatry team, and a decision was made to refer M to a child psychiatry unit in a nearby hospital. A home visit was proposed to the mother, but she was unable to schedule it in. She was seen in our outpatient clinic with her mother and appeared cheerful and happy to be home. M was worried however, as her parents threatened to send her back to the group home should she misbehave. M's parents defaulted their appointment with the child psychiatrist and with our psychiatry clinic subsequently. Despite multiple phone calls, the parents remain uncontactable. The welfare department had offered to re-home her, but the parents refused. Due to the previous court case, the welfare department made a decision to discharge M in her parents care and are unable to intervene further.

Discussion

M presented with a diagnostic conundrum as her symptoms of self - harm and precocious sexual behaviour needed to be managed accurately and urgently. She had multiple behavioural symptoms and yet they were sub-threshold presentations and did not fit the DSM 5 criteria. More urgently, she was at risk of being further exploited and endangered.

Initially a V code diagnosis of Parent-Child relational disorder was considered. This disorder is purely attributed to the relationship difficulties between the child and parent, and there is no other mental health diagnosis [5,10]. The aberrant relationship between parent and child is solely responsible for the impaired functioning and the focus of treatment is only the troubled relationship [10]. The parental under involvement and lack of interference in M's major life milestones leaned towards this diagnosis [10]. However, M's predominant psychopathology cannot be dismissed. The multiple self- harming episodes are unlikely to be solely due to the conflict with her parents.

M did not fulfil the criteria for Conduct Disorder, despite the occasional episodes of playing truant. There has been no violation of other individuals' rights or property [5]. M clearly did not have

a lack of empathy and was observed to be caring and kind by the ward staff. M has an obvious history of neglect and disrupted attachment. The lack of a consistent caregiver, especially in her early years is evident. There has been a paucity of research on adolescents with DSED as it is usually diagnosed below the age of 5 [12]. However, more and more adolescents are being diagnosed with DSED, as it may have been missed in childhood; thus, necessitating retrospective diagnoses [2,4,9,11]. Despite that, RAD and subsequently DSED remains an ill-defined adolescent disorder with an unknown prevalence [9]. Rutter's landmark study involving Romanian orphans, who when assessed at age 11, did display disinhibition and inappropriate physical contact with adults [9]. Adolescents with DSED also display signs of Cluster B emerging personality disorders, which is seen in M's case [4]. The treating team felt that the signs of DSED were present from a young age but were never recognised by her family. The symptoms were only first seen after her first sexual assault in 2017.

Managing DSED in an adolescent proved another challenge. DSED is commonly associated with other disorders such as Attention Deficit Hyperactive Disorder, conduct disorder and mood disorders [2,4]. M was assessed and did not meet the criteria for these disorders thus no pharmacotherapy was deemed necessary. Managing DSED in older children focuses on behavioural therapy, for both the child and caregiver. A supportive environment has to be established and slowly setting limits on the child behaviour i.e. authoritative parenting [2,4]. Unfortunately, as the parents defaulted treatment, the onus remains with the welfare department to step in.

Conclusion

Mental health workers should be trained to diagnose DSED in older children in rare situations such as this. The diagnosis should not be completely eliminated after the age of 5, but perhaps diagnosed retrospectively. The specific behavioural therapy needed for children with DSED can be honed among psychiatrists.

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