



A Case Study of Disinhibited Social Engagement Disorder: Longitudinal Research; Phase One

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Abstract

Disinhibited Social Engagement Disorder (DSED) is a relatively rare attachment disorder within Arab contexts, often arising from inconsistent caregiving or early neglect. This study aims to present and examine the case of a young child (case code: O3) observed over nearly three years and nine months (about 45 months, from March 2022 to December 2025), with over 100 direct observations. The appearance of DSED symptoms was studied in relation to multiple caregivers and unintentional neglect, the lack of diagnosed neurological or developmental conditions, and the ongoing presence of language delay and non-organic urinary incontinence.

The study utilised structured and semi-structured clinical observations, caregiver interviews, qualitative and quantitative analyses of behavioural changes over time (including monthly frequency charts), and retrospective application of standardised measures (Disturbances of Attachment Interview; Child–Parent Relationship Scale) with detailed raw scores. A straightforward, non-drug behavioural intervention was implemented in a natural environment from 1 year and 8 months of age, showing a gradual and sustained decrease in the target behaviour.

The results revealed a consistent pattern of uninhibited social engagement from an early age, with partial improvement following a straightforward behavioural intervention, and the persistence of some impulsive and self-injurious behaviours. The study discusses the findings in the context of the diagnostic system and considers confounding factors such as language delay, multiple caregivers, and family psychological stressors, emphasising ethical and practical considerations in early intervention within the Arab cultural setting.

Keywords: *Case study, Disinhibited Social Engagement Disorder, behavioural intervention.*

Introduction

Disinhibited Social Engagement Disorder (DSED), also known as Disinhibited Attachment Disorder, is an emotional condition in which a child shows no fear of unfamiliar adults and may even approach them. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), DSED can impair young children's ability to connect with adults and peers, leading to unsafe or risky situations. Common signs include sitting on a stranger's lap or leaving with an unfamiliar person. DSED mainly affects children and is seldom diagnosed before nine months of age unless symptoms are evident. Long-term studies suggest that DSED symptoms typically do not persist beyond age twelve. Children exposed to conflict or neglect are at higher risk of developing DSED (Guyon-Harris et al., 2019).

Disinhibited social engagement disorder (DSED) is one of the most prevalent clinical sequelae of severe neglect. In young children, it is characterised by overly familiar verbal or physical behaviour, a willingness to leave with an unfamiliar adult without hesitation, and a tendency not to track or check back with a caregiver in unfamiliar settings (Cowhey, 2024). DSED is also referred to as “indiscriminate friendliness,” “indiscriminate sociability,” or “disinhibited social behaviour” because affected children exhibit overly familiar behaviour or seek comfort and support from relatively unfamiliar adults, even when a familiar caregiver is present (Ali et al., 2024; Chisholm et al., 1995).

DSED occurs exclusively in children who have experienced severe psychosocial neglect and is characterised by the failure to show developmentally expected reticence about interacting with unfamiliar adults. Therefore, rather than being wary of strangers, children with DSED approach unfamiliar adults and initiate interactions that are physically or verbally intrusive, such as hugging, making physical contact, asking overly personal questions, or seeking comfort. They fail to stay close to or check back with their caregivers in unfamiliar settings and are even willing to depart with strangers without objection. In addition, children with DSED have significant difficulties relating interpersonally to peers (Cowhey, 2024). DSED describes a pattern of behaviours in maltreated youth characterised by the absence of developmentally appropriate reticence with unfamiliar adults (Cowhey, 2024).

Indiscriminate behaviour in early childhood has been extensively studied. Signs of DSED in early childhood have been consistently identified in samples of children in foster care and in those living in, or previously removed from, institutions (Gleason et al., 2014). However, despite a strong association with early psychosocial deprivation, past research indicates that removing children from institutional care does not reduce signs of DSED in all children (Lawler et al., 2016). Children with signs of DSED in early life are at increased risk of psychopathology and peer difficulties (Ali et al., 2024). In middle childhood and adolescence, signs of DSED are also associated with a history of psychosocial deprivation (Sonuga-Barke et al., 2017).

Children with DSED were consistently reported to have poorer social competencies than non-maltreated peers and environmental controls. Greater peer problems were consistently observed and may be associated with low self-esteem and a negative perception of social acceptance. In conclusion, children with DSED present with social relationship problems beyond the core symptoms of the disorder, but the relative impact of co-occurring neurodevelopmental conditions remains unclear (Davidson et al., 2024).

Signs and Symptoms: The primary and most recognised side effect is an unexpected ease in interacting with strangers. When a child with DSED is engaged in conversation, contact, or accompanies a stranger adult, they often show no signs of fear or unease. The signs and symptoms may include:

- Excessively recognisable verbal or physical conduct that isn't consistent with socially endorsed and appropriate social limits, or that appears unusual for their current age
- Absence of reservation regarding approaching and communicating with new adults
- Decreased or missing seeking out a grown-up parental figure after ceaseless wandering, even in new settings
- Eagerness to go off with a new grown-up, with little or no hesitation

Disordered attachment is linked to DSED, characterised by a need for intimacy, fear of rejection, and challenging mental states and behaviours. This style combines restlessness with avoidance. Confused attachment often appears in children in childcare facilities. These children are at increased risk of developing DSED, especially if they experienced parental neglect early in life, making this condition common among children with DSED. DSED can present with symptoms typically associated with hyperactivity, and it may be accompanied by delays in intellectual development, language, and discourse.

Risk Factors DSED:

DSED results from the absence or contradiction of important guardians during the first few years of childhood. During hospitalisation, typical children may experience conflicting thoughts or become distant. Attachment is harmed by parental concerns such as depression, sadness, behavioural problems, non-appearance, neediness, adolescent nurturing, or substance abuse.

Diagnosis:

The criteria for Disinhibited Social Engagement Disorder in the DSM-5-tr (APA, 2022) are:

- A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:
 - a. Reduced or absent reticence in approaching and interacting with unfamiliar adults.

- b. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
 - c. Diminished or absent checking back with adult caregiver after venturing
 - d. away, even in unfamiliar settings.
 - e. 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:
- a. Social neglect or deprivation in the form of persistent lack of having basic
 - b. emotional needs for comfort, stimulation, and affection met by caregiving adults.
 - c. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
 - d. 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 (DSM-5-TR, p 299-300)

Also, according to the World Health Organisation (WHO, 2019), International Classification of Diseases (ICD 11), Disinhibited social engagement disorder is characterized by grossly abnormal social behaviour, occurring in the context of a history of grossly inadequate child care (e.g., severe neglect, institutional deprivation).

The child approaches adults indiscriminately, lacks reticence to approach, will go away with unfamiliar adults, and exhibits overly familiar behaviour towards strangers.

Disinhibited social engagement disorder can only be diagnosed in children, and features of the disorder develop within the first 5 years of life.

However, the disorder cannot be diagnosed before the age of 1 year (or a developmental age of less than 9 months), when the capacity for selective attachments may not be fully developed, or in the context of Autism spectrum disorder.

Exclusions: Asperger syndrome Adjustment disorder Attention deficit hyperactivity disorder, reactive attachment disorder of childhood (ICD11, chap. 06, p50)

Treatment: Play therapy and expressive therapy are two effective treatment options that facilitate connection through various physical methods. Nonverbal approaches, such as play therapy, involve children using toys to "play" and relate to weather elements to address their issues and better understand their environment. This method lets children choose the outcomes of their play, giving them a sense of control. It is suitable for children aged 3 to 11 and can also serve as an assessment tool. Additionally, this therapy can help in understanding and analysing the child's needs. It combines psychodynamic and Cognitive-Behavioral therapy techniques (Hatam et al., 2021; Zeanah et al., 2016).

Using a different approach, a study examined the progression of DSED signs in children who experienced severe early deprivation from early childhood to early adolescence, using both variable-centred (linear mixed modelling) and person-centred (growth mixture modelling) methods. The sample included 124 children with a history of institutional care from a randomised controlled trial of foster care versus institutional care, along with 69 community children matched by age and sex. DSED signs were assessed at baseline (average age 22 months), and at 30, 42, 54 months, as well as at 8 and 12 years old, using a validated caregiver report of disturbed attachment behaviour. Results from variable-centred (intent-to-treat) analyses revealed a sharp decline in DSED signs among children assigned to foster care, while signs remained relatively high but slightly decreased in children receiving usual care. The study concluded that early and sustained family placements post-deprivation are associated with minimal or declining DSED signs across development. Reducing institutional care duration and maintaining placements could help lower DSED signs into early adolescence among previously institutionalised children (Guyon-Harris et al., 2018).

Prevalence of DSED: Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED) are uncommon in the general population, with estimates ranging from 0.9–1.4%. In high-risk populations, they are common: 49% in adopted children aged 6–11; 16% in adolescents in residential care; and 52% in young offenders attending specialist child mental health services (see Moran et al., 2023).

Relatedly, in a cross-sectional study, 110 male inmates aged 16 to 23 were examined for the prevalence of and associations between adverse childhood experiences and neurodevelopmental and mental health conditions, including Reactive Attachment Disorder and Disinhibited Social Engagement Disorder. The results showed that 53.6% had symptoms of Reactive Attachment Disorder and/or Disinhibited Social Engagement Disorder,

and 74.5% had experienced some form of abuse or neglect (Moran et al., 2003).

In Iraq, a study aimed to examine Disinhibited Social Engagement Disorder (DSED) among juvenile delinquents in correctional institutions by determining its prevalence, identifying its behavioural and psychological manifestations, and assessing potential gender differences. The study adopted a descriptive methodology to describe and interpret the phenomenon. The sample comprised 1,200 juvenile delinquents, including 779 males and 421 females, aged 16–21 years, drawn from six Iraqi governorates. A translated and culturally adapted instrument was used to measure DSED in a manner appropriate to the Iraqi context. The results indicated a notable prevalence of 20.17% in the total sample, with no statistically significant differences between males and females. The most common behavioural and psychological indicators were indiscriminate social behaviour, poor awareness of personal boundaries, and rapid social engagement with strangers. These findings suggest that the institutional environment and social context play a more influential role in the development of the disorder than biological factors or gender-related differences (Abdulwahab & Jasim, 2026).

Methodology

Study Design

A longitudinal approach is particularly valuable for monitoring the development of DSED signs from early childhood through adolescence in children who have experienced deprivation. This approach forms the basis of the current case study. It is a descriptive-analytical, longitudinal case study that includes repeated clinical observations, both unstructured and semi-structured interviews with caregivers, and qualitative as well as quantitative analyses of behavioural changes over time, such as monthly frequency tables and graphical timelines.

Ethical Consideration: The mother provided written consent for the study, which was conducted in line with the Ethical Considerations of the Jordanian Clinical Psychologists Association.

Family History

Mother's information: Current age 47, born 1978

She holds a bachelor's degree in sports and physical education and works as a teacher in schools under the Ministry of Education. After school hours, she works part-time as a sports trainer at a gym.

Mother's medical history: No notable medical history recorded.

In general, the mother exhibited a general lack of concern for her children's hygiene and nutrition (for example, the child in the study had allergies, and she would feed him, or forget, that he was prohibited from eating foods

that triggered his allergies).

This neglect was multifaceted, stemming from work, family problems and conflicts, and a lack of awareness (phrases frequently heard included: "What can I do?", "I'm just trying to catch up," "What's the big deal?", "We were all raised normally," and so on).

Marriages:

First marriage at age 23; she had one son, now 22 and in prison (see later).

Second marriage at age 32; she had a 13-year-old son, a 9-year-old daughter, and the boy who is the subject of the current study. All live with the mother and her current husband.

Children's Information:

The eldest son, aged 22, lived with his mother following her divorce and continued to reside with her even after she remarried. He started university at 21 but was then imprisoned, having not completed even a year there. He also sat his high school exams three times. Behavioural observations of the first child from the first marriage: The mother reported no problems during pregnancy or delivery, and the birth was normal. The pregnancy and delivery lasted a typical duration. Regarding his developmental history, as the mother described, he began saying "Baba" and "Mama" at one year old and started walking at 11 months. The mother states he was stubborn (between 3 and 5 years old, refusing orders, getting angry, and potentially breaking things if he did not get what he wanted), before or after her re-marriage. He attended kindergarten, where he displayed violence and hit other children, and began school at the age of 6. At school, his grades were average, and according to his mother, he associated with unproductive and failing students. At 10-11 years old, he began skipping school (truancy), and the school noted that he sometimes stole, harmed animals, and had issues with his peers. At 12-13 years old, he caused trouble with neighbours, in the street, and at school, and he was observed smoking (the school would contact his guardian, and his biological father would visit). He even caused problems with relatives.

At 15-20 years old, the problems continued and persist to this day. For example, he caused a disturbance in the neighbourhood. The police were called, he was arrested, and released on bail. This behaviour was repeated 4-5 times, resulting in his arrest by the police. At 21 years old, he assaulted a police officer, was arrested by the governor, and sentenced to (2.5) years and remains in prison. He also causes trouble with other inmates. (His mother claimed she had not noticed any signs of drinking or drug use.)

Children from the second marriage:

1. A 13-year-old boy. The mother reports no notable observations regarding his behaviour, and his academic performance is average. His relationship with his sister is normal, and his case is under review. His relationships at school, with neighbours, and in the neighbourhood are also normal.
2. A 9-year-old girl. The mother reported no behavioural or school-related observations.
3. Current case: date of birth: June 19, 2021, male. (O3)

Family and Caregiver Context

Since birth, the child has had multiple caregivers (biological mother, nursery, grandmother), with occasional daily changes in the primary caregiver due to the mother's employment. The transition to the current nursery mother began at the age of 6 months, and she remains the child's second caregiver. Daily care hours are estimated at 5–6 hours for the mother, 6–7 hours for the nursery (5 days a week), and 10–20 hours per week for the grandmother. There is no apparent environmental deprivation, and primary care is available.

The data indicated unintentional neglect due to a lack of conflict experience, as well as the child's repeated exposure to family disputes and issues with the older brother, which could affect the mother so that she is unable to provide full care for O3.

Case Information: O3

Gender: Male

Date of Birth: June 19, 2021

Age at First Observation: 9 months (March 2022), with formal assessment commencing after 5 initial observations.

Age at Last Follow-up: 4.5 years (December 26, 2025)

Language: Arabic (a single local dialect spoken by all caregivers)

Medical and Developmental Background

The pregnancy and delivery were normal and uncomplicated. The birth weight was 2,920 grams, the head circumference was 34 cm, and the length was 49 cm. There was no history of neurological or chronic illness, and no long-term medications were used. General medical examinations, including hearing and vision assessments, were normal. Neuroimaging studies (CT, MRI, EEG) were not performed due to the absence of clinical indications. The child was fully vaccinated according to the national immunisation programme and was under regular follow-up care by a paediatrician at the government health centre.

Motor development was normal (sitting at 5-6 months, crawling at 8 months, walking at 1 year).

Significant and persistent language delays were observed, with verbal expression limited to unintelligible sounds until 4.5 years of age, and vocalisations began in the last year. Diapers were still in use, and there were issues with urinary incontinence (incontinence despite training attempts). An organic cause was ruled out following a urological examination.

In early childhood (before 1 year and up to 1.5 years), symptoms such as fever, vomiting, hysterical crying, and a rash after eating were initially diagnosed as possible allergies (most likely lactose, animal protein, nuts, occasional eggs, and occasional oranges), with a prescription for special milk and the avoidance of foods like wheat. Later, gastroesophageal reflux was diagnosed and treated appropriately. The symptoms resolved approximately a year ago, and the child is currently symptom-free.

Caregiver Context:

Since birth, the child has had multiple caregivers (biological mother, nursery, grandmother), with occasional daily changes in the primary caregiver due to the mother's employment. The transition to the current nursery occurred at 6 months of age, and it remains the child's second caregiver. Daily care hours were estimated at 5–6 hours for the mother, 6–7 hours for the nursery staff (five days a week), and 10–20 hours per week for the grandmother. There is no apparent environmental deprivation, and basic care is available.

The data indicate unintentional neglect related to inexperience, along with the child's frequent exposure to family conflicts and issues between siblings (both full and half-siblings). The biological mother is also involved.

– Key Clinical Observations

Since 9 months of age, the child has exhibited a consistent pattern of:

Excessive approach to unfamiliar adults, lack of hesitation or social caution, physical initiative (such as clinging, attempting to climb to be held, grasping the stranger's hand to leave), and immediately going with strangers without consulting the caregiver.

These behaviours have been accompanied by impulsive outbursts, intense anger, defiance, and self-harming activities (head-banging, throwing objects). About a month ago, the child started nail-biting and seemed to enjoy it.

Assessment Procedures:

To ensure diagnostic accuracy and track the case's developmental and behavioural progress over approximately 45 months (from March 2022 to December 2025), the study employed a multi-method, multi-

informant assessment approach. The assessment procedures included the following components:

A. Triangulated Clinical Assessment:

To avoid bias from single-observer analysis, the assessment was based on data triangulation across three main axes:

1. **Clinical Observation in the Natural Environment (Researcher Axis):** Direct observation provided the foundation, with over 100 observation sessions conducted in the child's natural environments (home and daycare) over three years and nine months. These sessions aimed to observe spontaneous behaviours and the child's interactions with strangers and caregivers.
2. **Clinical Interviews (Biological Mother Axis):** Approximately 35 semi-structured clinical interviews were conducted with the mother to collect a detailed developmental and family history, assess care dynamics, and observe the child's interactions within broader social contexts.
3. **Ongoing Follow-up (Foster Axis):** Regular weekly telephone follow-ups were conducted with the nursery (second caregiver) to ensure that subtle behavioural changes in the alternative care setting were monitored in the mother's absence.

B. Retrospective Psychometric Evaluation: To prevent any early intervention that might alter the child's natural behaviour or influence the caregivers' awareness (Hawthorne Effect), the scales were not administered directly at the start of observation. Instead, they were applied retrospectively, using a "clinical coding matrix" to organise and quantify the cumulative observations from the three preceding axes to minimise recall bias. These axes included:

- **Disturbances of Attachment Interview (DAI):** A semi-structured scale comprising 12 items, scored based on the frequency of behaviour (0 = rarely/never; 1 = sometimes; 2 = always). The focus was on the dimensions of lack of attachment, indiscriminate behaviour, and deviations from the secure baseline. The assessments revealed high raw scores in the indiscriminate behaviour dimension (6/6), with the items: excessive approach (item 6), lack of reserve (item 7), and willingness to leave with strangers (item 8) scoring the maximum (2).
 - **Child-Parent Relationship Scale (CPRS):** This 30-item scale on a five-point Likert scale was used to assess the quality of the dyadic relationship with the primary caregiver. The results showed a disrupted pattern, with a significant decrease in the emotional closeness dimension (raw 12/35; mean 1.71/5) and a notable increase in the conflict dimension (raw 28/40; mean 3.5/5), along with moderate dependency levels.
4. **Behavioural Intervention:** A straightforward, non-drug behavioural intervention was implemented in a natural environment from 1 year and 8 months of age (February 2023). The intervention involved using

a conditioned auditory cue (tapping on a metal plate) to encourage the impulsive child to approach strangers. This cue was employed descriptively on a daily basis as needed, without a strict schedule. It was complemented by psychoeducational training for the mother and caregiver to promote consistent responsiveness and emotional reinforcement.

Results

- A. Core Clinical Observations: Since reaching 9 months of age, the child has demonstrated a consistent behavioural pattern aligned with the criteria for DSED, characterised by: excessive approach towards unfamiliar adults, absence of hesitation or social caution, inappropriate physical actions (such as attempting to cling, requesting to be held, grasping strangers' hands), and immediately following strangers without consulting the caregiver. These symptoms have been accompanied by severe temper tantrums, impulsivity, defiance, and self-harming behaviours (such as head-banging and throwing objects). More recently (about one month ago), the child has developed a nail-biting habit accompanied by expressions of enjoyment and pleasure. These observations align with the results of the retrospective scales. The DAI confirmed that the criteria for non-inhibitory behaviour were met, without supporting evidence for Reactive Attachment Disorder (RAD). In contrast, the CPRS indicated a relationship characterised by low emotional closeness, high conflict, and poor co-regulation.
- B. Quantitative assessment and statistical analysis of behaviour development: To evaluate the effectiveness of the behavioural intervention, the frequency of the "engaging with strangers" behaviour was estimated based on monthly descriptive frequency tables (weekly average on a 0-20 event scale).

Months Since Baseline (March 2022)	Mean Weekly Frequency of Inappropriate Approach	Clinical Notes
0–3	15	Very high, pre-intervention
4–6	14	Persistence of behavior
7–10	13	Initial mild improvement
11–12 (Intervention Phase)	12	Approx. 10% initial reduction
13–18	11	Continued gradual improvement
19–24	10	Approx. 20% overall reduction
25–30	9	Relatively stable
31–36	9	Minimal additional decline
37–45	9	Plateau; ~30% improvement achieved after 34 months of intervention

A visual trend analysis shows a gradual and sustained decrease in the target behaviour following the start of the intervention, with an initial slowdown, then a plateau. Although the data indicate a clinically significant improvement (about 30% reduction from baseline), no formal inferential statistical analyses were performed due to the single-case design.

In conclusion, the case study showed that, in the first phase, the child exhibited some improvements; yet, he still requires further assessment and intervention and that will take place in the second phase.

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