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Chapter 1 : The DSM Classification and criteria changes

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In the DSM-5 classification, the chapter on schizophrenia and other psychotic disorders is sequenced with that of bipolar and related disorders which are now separated from unipolar mood disorders , which is then followed by the chapter on depressive disorders. Incidentally, these comprise the first four chapters of the DSM A similar pattern â€" grouping based more so on neuroscience and less on symptom expression â€" also occurs within the diagnostic categories. For trichotillomania, similarities to obsessive-compulsive disorder and to other body-focused, repetitive pathologies e. The internalizing disorders, with high levels of negative affectivity, include depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders, and dissociative disorders. Somatic disorders also frequently co-occur with the emotional or internalizing disorders, that include somatic symptom and related disorders, feeding and eating disorders, sleep-wake disorders, and sexual dysfunctions. Externalizing disorders include disruptive, impulse control, and conduct disorders, and the substance-related and addictive disorders In evolving toward a structure that more closely follows this approach, the DSM-5 includes dimensional aspects of diagnosis along with categories. This proposed revision was developed because of the presence of very poor reliability data, that failed to validate their continued separation Although the DSM-5 describes all of these presentations under one rubric, specifiers are provided to account for ASD variations, including specifiers for the presence or absence of intellectual impairment, structural language impairment, co-occurring medical conditions, or loss of established skills. Finally, integration of dimensions in the DSM-5 is encouraged for further study and clinical experience. Such dimensional assessment can be applied across disorders through use of cross-cutting quantitative assessments. If criteria for a diagnosis are fulfilled, a third level of dimensional assessment can help establish severity. The score suggests the possible presence of major depressive disorder, and after a clinical interview that assesses the presence of diagnostic criteria, a depression diagnosis may be given. The Nine-Item Patient Health Questionnaire can then be administered to establish baseline severity, with repeated administration at regular intervals as clinically indicated for monitoring course and treatment response. While the first level cross-cutting measure is provided in the printed DSM-5, all three levels of dimensional measures are provided in the electronic version of the manual for downloading and clinical use without additional charge. An abbreviated description of the major deviations from the DSM-IV can be found in the Appendix of the manual itself, with a more detailed version online http: What follows below is a select summary of revisions. Combining and splitting DSM-IV disorders Some disorders were revised by combining criteria from multiple disorders into a single diagnosis, as in instances where there was a lack of data to support their continued separation. The most publically discussed example of this is ASD. Somatic symptom disorder largely takes the place of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder, although many individuals previously diagnosed with hypochondriasis will now meet criteria for illness anxiety disorder new to DSM Further, the addition of severity ratings for substance use disorder enables a diagnosis of mild substance use disorder, that will be coded separately with the ICD code for substance abuse in DSM-IV from moderate-to-severe levels coded with the ICD codes previously used for substance dependence. Despite a shared etiology i. The two subtypes also demonstrate disparities in course and treatment response; thus, each was elevated to a separate full disorder in the DSM-5 Specifiers and subtypes Specifiers and subtypes delineate phenomenological variants of a disorder indicative of specific subgroupings, which impact, among other outcomes, on treatment planning and treatment developments. Specific treatment interventions have been developed that are more successful with this subgroup. In addition to the core criteria for major and mild NCD, ten etiological subtypes are now provided, with separate criteria and text for each. However, there are important and often subtle differences between these disorders, as greater information on post-mortem laboratory correlations and clinical

progression have become available over the past two decades. Many, but not all, of these subtypes were described briefly in the DSM-IV, but the DSM-5 recognizes each separately and in greater detail to give clinicians more guidance in determining possible etiology. New disorders A rigorous review process was established for assessing all proposed revisions to the DSM-5, and those suggesting inclusion of new disorders were among the most stringently assessed. Disruptive mood dysregulation disorder DMDD was proposed in response to a decade-long debate about whether or not chronic irritability in children is a hallmark symptom of pediatric bipolar disorder. With the prevalence of childhood bipolar disorders growing at an alarming rate, the DSM-5 Childhood and Adolescent Disorders Work Group compared evidence from natural history and treatment studies of classic bipolar disorder versus bipolar disorder diagnosed using non-episodic irritability as a criterion, and determined that separate disorders based on episodic versus persistent irritability were justified Therefore, children with extreme behavioral dyscontrol but non-episodic irritability no longer qualify for a diagnosis of bipolar disorder in the DSM-5 and instead would be considered for DMDD. Under the DSM-IV, individuals exhibiting symptoms of major depressive disorder were excluded from diagnosis if also bereaved within the past 2 months. The intention was to prevent individuals experiencing normal grief reactions to loss of a loved one from being labeled as having a mental disorder. Unfortunately, this also prevented bereaved individuals who were experiencing a major depressive episode from being appropriately diagnosed and treated. It also implied an arbitrary time course to bereavement and failed to recognize that experiences of major loss â€" including losses other than the death of a loved one, like job loss â€" can lead to depressive symptoms that needed to be distinguished from those associated with a major depressive disorder. Although symptoms of grief or other losses can mimic those of depression and do not necessarily suggest a mental disorder, for the subset of individuals whose loss does lead to a depressive disorder or for whom a depressive disorder was already present , appropriate diagnosis and treatment may facilitate recovery. As a result, the bereavement exclusion was lifted and replaced with much more descriptive guidance on the distinction between symptoms characteristic of normal grief and those that are indicative of a clinical disorder Changes in naming conventions Revisions in commonly used terminology required an evaluation of the most appropriate terms for describing some mental disorders â€" an issue of particular concern for consumer-advocate organizations. Epidemiological studies will aid in detecting changes in prevalence and comorbidities from the DSM-IV, including implementation of cross-national surveys of disorders with high public health relevance worldwide, such as schizophrenia, major depressive disorder, and substance use disorders. The more immediate next steps for the DSM-5 include the development of materials that may assist in its use in primary care settings, adaptation of assessment instruments to DSM-5, and documenting the evidence base for revision decisions in the DSM-5 electronic archives. There will also be further testing and development of the dimensional assessments in the manual, including that of a pediatric version of the internationally used WHO Disability Assessment Schedule 2. By continuing collaboration with the WHO in future editions of the DSM, we can assure a more comparable international statistical classification of mental disorders and move closer to a truly unified nosology and approach to diagnosis. Such a collaborative effort should assist the , psychiatrists worldwide to better care for individuals with these life-altering and potentially destructive conditions, and advance a more synergistic and cumulative international research agenda to find the causes and cures for these disorders. Acknowledgments This paper is published thanks to an agreement with the American Psychiatric Association, which reserves the copyright. Diagnostic and statistical manual of mental disorders. American Psychiatric Association; Diagnosis and classification of mental disorders and alcohol- and drug-related problems: Sartorius N Principal Investigator. Manual of the international statistical classification of diseases, injuries, and causes of death. Tenth revision of the international classification of diseases. World Health Organization; ICD Classification of mental and behavioural disorders. Diagnostic criteria for research. Clinical descriptions and diagnostic guidelines. Evolution of the DSM-V conceptual framework: Regier D Principal Investigator. Public health aspects of diagnosis and classification of mental and behavioral disorders. Diagnostic issues in depression and generalized anxiety disorder: Somatic presentations of mental disorders: Dimensional models of personality disorders: Diagnostic issues in substance use disorders: Diagnostic issues in dementia: Dimensional approaches in diagnostic classification:

Stress-induced and fear circuitry disorders: Obsessive-compulsive behavior spectrum disorders: Robins E, Guze SB. Establishment of diagnostic validity in psychiatric illness: Where should bipolar ap-pear in the meta-structure? A new meta-structure of mental disorders: The genetic deconstruction of psychosis. Identification of risk loci with shared effects on five major psychiatric disorders: Trichotillomania hair pulling disorder , skin picking disorder, and stereotypic movement disorder: The structure of common mental disorders. Inappropriate prescriptions of antidepressant dr-ugs in patients with subthreshold to mild depression: A multisite study of the clinical diagnosis of different autism spectrum disorders. Report presented to the American Psychiatric Association, ; available online at http: Agosti V, Stewart JW. Hypomania with and without dysphoria: Mixed hypomania in patients with bipolar disorder evaluated prospectively in the Stanley Foundation Bipolar Treatment Network: Severe mood dysregulation, irritability, and the diagnostic boundaries of bipolar disorder in youths. The bereavement exclusion and DSM

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Attachment disorders are the psychological result of significant social neglect, that is, the absence of adequate social and emotional caregiving during childhood, disrupting the normative bond between children and their caregivers.

Attachment theory and attachment disorder Pediatricians are often the first health professionals to assess and raise suspicions of RAD in children with the disorder. Infants up to about 18â€”24 months may present with non-organic failure to thrive and display abnormal responsiveness to stimuli. Laboratory investigations will be unremarkable barring possible findings consistent with malnutrition or dehydration , while serum growth hormone levels will be normal or elevated. This can manifest itself in three ways: Indiscriminate and excessive attempts to receive comfort and affection from any available adult, even relative strangers older children and adolescents may also aim attempts at peers. This may often times appear as denial of comfort from anyone as well. Extreme reluctance to initiate or accept comfort and affection, even from familiar adults, especially when distressed. Actions that otherwise would be classified as conduct disorder , such as mutilating animals , harming siblings or other family, or harming themselves intentionally. However, the instances of that ability are rare. Often a range of measures is used in research and diagnosis. Recognized assessment methods of attachment styles, difficulties or disorders include the Strange Situation Procedure devised by developmental psychologist Mary Ainsworth , [13] [14] [15] the separation and reunion procedure and the Preschool Assessment of Attachment, [16] the Observational Record of the Caregiving Environment, [17] the Attachment Q-sort [18] and a variety of narrative techniques using stem stories , puppets or pictures. For older children, actual interviews such as the Child Attachment Interview and the Autobiographical Emotional Events Dialogue can be used. Caregivers may also be assessed using procedures such as the Working Model of the Child Interview. This method is designed to pick up not only RAD but also the proposed new alternative categories of disorders of attachment. Causes[edit] Although increasing numbers of childhood mental health problems are being attributed to genetic defects , [21] reactive attachment disorder is by definition based on a problematic history of care and social relationships. Abuse can occur alongside the required factors, but on its own does not explain attachment disorder. The issue of temperament and its influence on the development of attachment disorders has yet to be resolved. RAD has never been reported in the absence of serious environmental adversity yet outcomes for children raised in the same environment are the same. The subsequent development of higher-order self-regulation is jeopardized and the formation of internal models is affected. Consequently, the "templates" in the mind that drive organized behavior in relationships may be impacted. The potential for "re-regulation" modulation of emotional responses to within the normal range in the presence of "corrective" experiences normative caregiving seems possible. There is little systematic epidemiologic information on RAD, its course is not well established and it appears difficult to diagnose accurately. The signs or symptoms of RAD may also be found in other psychiatric disorders and AACAP advises against giving a child this label or diagnosis without a comprehensive evaluation. Attachment behaviors used for the diagnosis of RAD change markedly with development and defining analogous behaviors in older children is difficult. There are no substantially validated measures of attachment in middle childhood or early adolescence. The two classifications are similar and both include: ICD states in relation to the inhibited form only that the syndrome probably occurs as a direct result of severe parental neglect, abuse, or serious mishandling. In DSM-IV-TR the inhibited form is described as persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses e. The disinhibited form shows diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments e. The first of these is somewhat controversial, being a commission rather than omission and because abuse in and of itself does not lead to attachment disorder. The inhibited form has a greater tendency to ameliorate with an appropriate caregiver, while the disinhibited form is more enduring. Disinhibited and inhibited are not opposites in terms of attachment disorder and can coexist in the same child. The World Health Organization acknowledges that there is uncertainty regarding the diagnostic criteria and

the appropriate subdivision. RAD can also be confused with neuropsychiatric disorders such as autism , pervasive developmental disorder , childhood schizophrenia and some genetic syndromes. Infants with this disorder can be distinguished from those with organic illness by their rapid physical improvement after hospitalization. They are unlikely to improve upon being removed from the home. These lists are unvalidated and critics state they are inaccurate, too broadly defined or applied by unqualified persons. Many are found on the websites of attachment therapists. However, knowledge of attachment relationships can contribute to the cause, maintenance and treatment of externalizing disorders. Critics assert that it is unvalidated [44] and lacks specificity. Zeanah based on its published parameters for the diagnosis and treatment of RAD. After ensuring that the child is in a safe and stable placement, effective attachment treatment must focus on creating positive interactions with caregivers. The programs invariably include a detailed assessment of the attachment status or caregiving responses of the adult caregiver as attachment is a two-way process involving attachment behavior and caregiver response. Some of these treatment or prevention programs are specifically aimed at foster carers rather than parents, as the attachment behaviors of infants or children with attachment difficulties often do not elicit appropriate caregiver responses. Attachment therapy The terms attachment disorder , attachment problems, and attachment therapy, although increasingly used, have no clear, specific, or consensus definitions. However, the terms and therapies often are applied to children who are maltreated, particularly those in the foster care, kinship care, or adoption systems, and related populations such as children adopted internationally from orphanages. Sufferers of "attachment disorder" are said to lack empathy and remorse. Treatments of this pseudoscientific disorder are called "Attachment therapy". In general, these therapies are aimed at adopted or fostered children with a view to creating attachment in these children to their new caregivers. The theoretical base is broadly a combination of regression and catharsis , accompanied by parenting methods which emphasize obedience and parental control. These forms of the therapy may well involve physical restraint, the deliberate provocation of rage and anger in the child by physical and verbal means including deep tissue massage, aversive tickling, enforced eye contact and verbal confrontation, and being pushed to revisit earlier trauma. The few existing longitudinal studies dealing with developmental change with age over a period of time involve only children from poorly run Eastern European institutions. However, there is a close association between duration of deprivation and severity of attachment disorder behaviors. Some exhibit hyperactivity and attention problems as well as difficulties in peer relationships. In one investigation, some institution-reared boys were reported to be inattentive, overactive, and markedly unselective in their social relationships, while girls, foster-reared children, and some institution-reared children were not. It is not yet clear whether these behaviors should be considered as part of disordered attachment. This study assessed the twins between the ages of 19 and 36 months, during which time they suffered multiple moves and placements. The girl showed signs of the inhibited form of RAD while the boy showed signs of the indiscriminate form. It was noted that the diagnosis of RAD ameliorated with better care but symptoms of post traumatic stress disorder and signs of disorganized attachment came and went as the infants progressed through multiple placement changes. At age three, some lasting relationship disturbance was evident. In the follow-up case study when the twins were aged three and eight years, the lack of longitudinal research on maltreated as opposed to institutionalized children was again highlighted. The boy still exhibited self-endangering behaviors, not within RAD criteria but possibly within "secure base distortion", where the child has a preferred familiar caregiver, but the relationship is such that the child cannot use the adult for safety while gradually exploring the environment. The girl showed externalizing symptoms particularly deceit , contradictory reports of current functioning, chaotic personal narratives, struggles with friendships, and emotional disengagement with her caregiver, resulting in a clinical picture described as "quite concerning". The boy still evidenced self-endangering behaviors as well as avoidance in relationships and emotional expression, separation anxiety and impulsivity and attention difficulties. It was apparent that life stressors had impacted each child differently. The narrative measures used were considered helpful in tracking how early attachment disruption is associated with later expectations about relationships. These differences were especially pronounced based on ratings by parents, and suggested that children with RAD may systematically report their personality traits in overly positive ways. Their scores also indicated considerably more behavioral

problems than scores of the control children. The difference between the institutionalized children and the control group had lessened in the follow-up study three years later, although the institutionalized children continued to show significantly higher levels of indiscriminate friendliness. The first, in , reported that children from the maltreatment sample were significantly more likely to meet criteria for one or more attachment disorders than children from the other groups, however this was mainly the proposed new classification of disrupted attachment disorder rather than the DSM or ICD classified RAD or DAD. However, there are some methodological concerns with this study. A number of the children identified as fulfilling the criteria for RAD did in fact have a preferred attachment figure. These are principally developmental delays and language disorders associated with neglect. Attachment theory and Attachment in children Reactive attachment disorder first made its appearance in standard nosologies of psychological disorders in DSM-III, , following an accumulation of evidence on institutionalized children. The criteria included a requirement of onset before the age of 8 months and was equated with failure to thrive. Instead, onset was changed to being within the first 5 years of life and the disorder itself was divided into two subcategories, inhibited and disinhibited. Both nosologies focus on young children who are not merely at increased risk for subsequent disorders but are already exhibiting clinical disturbance. Attachment theory is a framework that employs psychological , ethological and evolutionary concepts to explain social behaviors typical of young children. Attachment theory focuses on the tendency of infants or children to seek proximity to a particular attachment figure familiar caregiver , in situations of alarm or distress, behavior which appears to have survival value. Subsequently, the child begins to use the caregiver as a base of security from which to explore the environment, returning periodically to the familiar person. Attachment and attachment behaviors tend to develop between the ages of six months and three years. Infants become attached to adults who are sensitive and responsive in social interactions with the infant, and who remain as consistent caregivers for some time. The pathological absence of a discriminatory or selective attachment needs to be differentiated from the existence of attachments with either typical or somewhat atypical behavior patterns, known as styles or patterns. There are four attachment styles ascertained and used within developmental attachment research. These are known as secure, anxious-ambivalent, anxious-avoidant, all organized [13] and disorganized. These are assessed using the Strange Situation Procedure , designed to assess the quality of attachments rather than whether an attachment exists at all. The anxious-ambivalent toddler is anxious of exploration, extremely distressed when the caregiver departs but ambivalent when the caregiver returns. The anxious-avoidant toddler will not explore much, avoid or ignore the parentâ€”showing little emotion when the parent departs or returnsâ€”and treat strangers much the same as caregivers with little emotional range shown. Evidence suggests this occurs when the caregiving figure is also an object of fear, thus putting the child in an irresolvable situation regarding approach and avoidance. On reunion with the caregiver, these children can look dazed or frightened, freezing in place, backing toward the caregiver or approaching with head sharply averted, or showing other behaviors implying fear of the person who is being sought. It is thought to represent a breakdown of an inchoate attachment strategy and it appears to affect the capacity to regulate emotions. Such discrimination does exist as a feature of the social behavior of children with atypical attachment styles. Both DSM-IV and ICD depict the disorder in terms of socially aberrant behavior in general rather than focusing more specifically on attachment behaviors as such. DSM-IV emphasizes a failure to initiate or respond to social interactions across a range of relationships and ICD similarly focuses on contradictory or ambivalent social responses that extend across social situations. There is as yet no consensus, on this issue but a new set of practice parameters containing three categories of attachment disorder has been proposed by C. The first of these is disorder of attachment, in which a young child has no preferred adult caregiver. The second category is secure base distortion, where the child has a preferred familiar caregiver, but the relationship is such that the child cannot use the adult for safety while gradually exploring the environment. Such children may endanger themselves, cling to the adult, be excessively compliant, or show role reversals in which they care for or punish the adult. The third type is disrupted attachment.

Chapter 3 : Attachment disorder - Wikipedia

Attachment disorder is a broad term intended to describe disorders of mood, behavior, and social relationships arising from a failure to form normal attachments to primary care giving figures in early childhood.

The two classifications are similar and both include: The disturbance is not accounted for solely by developmental delay and does not meet the criteria for Pervasive Developmental Disorder. Onset before 5 years of age. Requires a history of significant neglect. Implicit lack of identifiable, preferred attachment figure. Unusually therefore part of the diagnosis is history of care rather than observation of symptoms. The disinhibited form shows: This is somewhat controversial, being a commission rather than omission and because abuse of itself does not lead to attachment disorder. The inhibited form has a greater tendency to ameliorate with an appropriate caregiver whilst the disinhibited form is more enduring. Abuse can occur alongside the required factors but on its own does not explain attachment disorder. It is associated with developed, albeit disorganized attachment. Within official classifications, attachment disorganization is a risk factor but not in itself an attachment disorder. Main article The theoretical framework for Reactive Attachment Disorder is attachment theory based on work by Bowlby , Ainsworth and Spitz, from the s to the s. Attachment theory is an evolutionary theory whereby the infant or child seeks proximity to a specified attachment figure in situations of alarm or distress, for the purpose of survival. Attachment and attachment behaviors tend to develop between the age of 6 months and 3 years. Infants become attached to adults who are sensitive and responsive in social interactions with the infant, and who remain as consistent caregivers for some time. RAD requires one or both of the attachment behaviors of proximity seeking to a specified attachment figure to be missing. Continuing discussion of the RAD category focuses both on detailed criteria and on precursors of the disorder. A disorder in the clinical sense is a condition requiring treatment, as opposed to risk factors for subsequent disorders. Children who are adopted after the age of six months are at risk for attachment problems. Problems with the caregiver-child relationship during that time, orphanage experience, or breaks in the consistent caregiver-child relationship interfere with the normal development of a healthy and secure attachment. There are wide ranges of attachment difficulties that result in varying degrees of emotional disturbance in the child. However, less than ideal attachment styles are not within the criteria for RAD. Some authors have proposed a broader continuum of definitions of attachment disorders ranging from RAD, through various attachment difficulties to the more problematic attachment styles but there is as yet no consensus on this issue. In particular, Zeanah and Boris, building on the earlier work of Leiberman, propose three categories; "disorder of attachment" to indicate a situation in which a young child has no preferred adult caregiver, parallel to Reactive Attachment Disorder as defined in DSM and ICD in its inhibited and disinhibited forms. Such children may endanger themselves, may cling to the adult, may be excessively compliant, or may show role reversals in which they care for or punish the adult. Chronic early maltreatment is one etiological element of Disorganized attachment , which can also lead to the development of the diagnosis, Reactive attachment disorder. These children may be risk of developing Reactive Attachment Disorder. These children may be described as experiencing trauma-attachment problems and are likely to develop Reactive Attachment Disorder [13] , which is a psychiatric diagnosis. The clinical formulation of [Complex post traumatic stress disorder]] is a clinical perspective on this set of problems [14]. There are no precise statistics on prevalence. The Taskforce did not agree with this view as severely abused children may exhibit similar behaviors to RAD behaviors and there are several far more common and demonstrably treatable diagnoses which may better account for these difficulties. Many children experience severe maltreatment but do not develop clinical disorders. The Taskforce states that it should not be assumed that RAD underlies all or even most of the behavioral and emotional problems seen in foster children, adoptive children, or children who are maltreated. There is a lack of clarity about the presentation of attachment disorders over the age of 5 years and difficulty in distinguishing between aspects of attachment disorders, disorganized attachment or the sequalae of maltreatment.

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the mandatory criteria found in Part I, Mandatory Criteriaof this attachment. Responses failing to comply with all mandatory criteria will not be considered for further evaluation.

By Saul McLeod , updated Attachment is a deep and enduring emotional bond that connects one person to another across time and space Ainsworth , ; Bowlby , Attachment does not have to be reciprocal. One person may have an attachment to an individual which is not shared. Attachment is characterized by specific behaviors in children, such as seeking proximity to the attachment figure when upset or threatened Bowlby, Such behavior appears universal across cultures. Attachment theory explains how the parent-child relationship emerges and influences subsequent development. Attachment theory in psychology originates with the seminal work of John Bowlby Specifically, it shaped his belief about the link between early infant separations with the mother and later maladjustment, and led Bowlby to formulate his attachment theory. John Bowlby , working alongside James Robertson observed that children experienced intense distress when separated from their mothers. The behavioral theory of attachment stated that the child becomes attached to the mother because she fed the infant. This is illustrated in the work of Lorenz and Harlow Most researchers believe that attachment develops through a series of stages. Stages of Attachment Rudolph Schaffer and Peggy Emerson studied 60 babies at monthly intervals for the first 18 months of life this is known as a longitudinal study. The children were all studied in their own home, and a regular pattern was identified in the development of attachment. The babies were visited monthly for approximately one year, their interactions with their carers were observed, and carers were interviewed. A diary was kept by the mother to examine the evidence for the development of attachment. Three measures were recorded: Stranger Anxiety - response to the arrival of a stranger. Separation Anxiety - distress level when separated from a carer, the degree of comfort needed on return. Social Referencing - the degree a child looks at their carer to check how they should respond to something new secure base. Asocial 0 - 6 weeks Very young infants are asocial in that many kinds of stimuli, both social and non-social, produce a favorable reaction, such as a smile. Indiscriminate Attachments 6 weeks to 7 months Infants indiscriminately enjoy human company, and most babies respond equally to any caregiver. They get upset when an individual ceases to interact with them. From 3 months infants smile more at familiar faces and can be easily comfortable by a regular caregiver. Specific Attachment 7 - 9 months Special preference for a single attachment figure. The baby looks to particular people for security, comfort, and protection. It shows fear of strangers stranger fear and unhappiness when separated from a special person separation anxiety. Some babies show stranger fear and separation anxiety much more frequently and intensely than others, nevertheless, they are seen as evidence that the baby has formed an attachment. This has usually developed by one year of age. Multiple Attachment 10 months and onwards The baby becomes increasingly independent and forms several attachments. By 18 months the majority of infants have formed multiple attachments. Schaffer and Emerson called this sensitive responsiveness. Intensely attached infants had mothers who responded quickly to their demands and, interacted with their child. Infants who were weakly attached had mothers who failed to interact. Many of the babies had several attachments by ten months old, including attachments to mothers, fathers, grandparents, siblings, and neighbors. The mother was the main attachment figure for about half of the children at 18 months old and the father for most of the others. The most important fact in forming attachments is not who feeds and changes the child but who plays and communicates with him or her. Therefore, responsiveness appeared to be the key to attachment. Attachment Theories Psychologists have proposed two main theories that are believed to be important in forming attachments. The basis for the learning of attachments is the provision of food. An infant will initially form an attachment to whoever feeds it. They learn to associate the feeder usually the mother with the comfort of being fed and through the process of classical conditioning , come to find contact with the mother comforting. They also find that certain behaviors e. The evolutionary theory of attachment e. The determinant of attachment is not food, but care and responsiveness. Bowlby suggested that a child would initially form only one primary attachment monotropy and that the attachment figure acted as a secure base for exploring the world. The

attachment relationship acts as a prototype for all future social relationships so disrupting it can have severe consequences. This theory also suggests that there is a critical period for developing an attachment about 0 -5 years. If an attachment has not developed during this period, then the child will suffer from irreversible developmental consequences, such as reduced intelligence and increased aggression. These infants were highly dependent on their mothers for nutrition, protection, comfort, and socialization. What, exactly, though, was the basis of the bond? The behavioral theory of attachment would suggest that an infant would form an attachment with a carer that provides food. His experiments took several forms: They had no contact with each other or anybody else. He kept some this way for three months, some for six, some for nine and some for the first year of their lives. He then put them back with other monkeys to see what effect their failure to form attachment had on behavior. The monkeys engaged in bizarre behavior such as clutching their own bodies and rocking compulsively. They were then placed back in the company of other monkeys. To start with the babies were scared of the other monkeys, and then became very aggressive towards them. They were also unable to communicate or socialize with other monkeys. The other monkeys bullied them. They indulged in self-mutilation, tearing hair out, scratching, and biting their own arms and legs. The extent of the abnormal behavior reflected the length of the isolation. Those kept in isolation for three months were the least affected, but those in isolation for a year never recovered the effects of privation. Four of the monkeys could get milk from the wire mother and four from the cloth mother. The animals were studied for days. Both groups of monkeys spent more time with the cloth mother even if she had no milk. The infant would only go to the wire mother when hungry. Once fed it would return to the cloth mother for most of the day. If a frightening object was placed in the cage the infant took refuge with the cloth mother its safe base. This surrogate was more effective in decreasing the youngsters fear. The infant would explore more when the cloth mother was present. This supports the evolutionary theory of attachment, in that it is the sensitive response and security of the caregiver that is important as opposed to the provision of food. The behavioral differences that Harlow observed between the monkeys who had grown up with surrogate mothers and those with normal mothers were; a They were much more timid. These behaviors were observed only in the monkeys who were left with the surrogate mothers for more than 90 days. For those left less than 90 days the effects could be reversed if placed in a normal environment where they could form attachments. Clinging is a natural response - in times of stress the monkey runs to the object to which it normally clings as if the clinging decreases the stress. He also concluded that early maternal deprivation leads to emotional damage but that its impact could be reversed in monkeys if an attachment was made before the end of the critical period. However, if maternal deprivation lasted after the end of the critical period, then no amount of exposure to mothers or peers could alter the emotional damage that had already occurred. Harlow found therefore that it was social deprivation rather than maternal deprivation that the young monkeys were suffering from. When he brought some other infant monkeys up on their own, but with 20 minutes a day in a playroom with three other monkeys, he found they grew up to be quite normal emotionally and socially. His experiments have been seen as unnecessarily cruel unethical and of limited value in attempting to understand the effects of deprivation on human infants. It was clear that the monkeys in this study suffered from emotional harm from being reared in isolation. This was evident when the monkeys were placed with a normal monkey reared by a mother , they sat huddled in a corner in a state of persistent fear and depression. Also, Harlow created a state of anxiety in female monkeys which had implications once they became parents. At the time of the research, there was a dominant belief that attachment was related to physical i. It could be argued that the benefits of the research outweigh the costs the suffering of the animals. For example, the research influenced the theoretical work of John Bowlby , the most important psychologist in attachment theory. Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. Child Development, 41, The development of infant-mother attachment. University of Chicago Press. Attachments and other affectional bonds across the life cycle. The nature of the childs tie to his mother. International Journal of Psychoanalysis, 39, A two-year-old goes to hospital. Proceedings of the Royal Society of Medicine, 46, â€” The development of affective responsiveness in infant monkeys.

Chapter 5 : Case Review App: Searching / Filtering Messages | Mimecaster Central

New DSA Requirements for Further Review of Solar Panel Attachment Details. Issued: August 11, Page. 2. of. 3. over the cyclical nature of wind events and prevent the dislodging of panels from the.

Attachment theory and Attachment in children Attachment theory is primarily an evolutionary and ethological theory. In relation to infants, it primarily consists of proximity seeking to an attachment figure in the face of threat, for the purpose of survival. Infants become attached to adults who are sensitive and responsive in social interactions with the infant, and who remain as consistent caregivers for some time. Basic trust is a broader concept than attachment in that it extends beyond the infant-caregiver relationship to " In the clinical sense, a disorder is a condition requiring treatment as opposed to risk factors for subsequent disorders. Reactive attachment disorder indicates the absence of either or both the main aspects of proximity seeking to an identified attachment figure. The words attachment style or pattern refer to the various types of attachment arising from early care experiences, called secure, anxious-ambivalent, anxious-avoidant, all organized , and disorganized. Discussion of the disorganized attachment style sometimes includes this style under the rubric of attachment disorders because disorganized attachment is seen as the beginning of a developmental trajectory that will take the individual ever further from the normal range, culminating in actual disorders of thought, behavior, or mood. Zeanah and colleagues proposed an alternative set of criteria see below of three categories of attachment disorder, namely "no discriminated attachment figure", "secure base distortions" and "disrupted attachment disorder". These classifications consider that a disorder is a variation that requires treatment rather than an individual difference within the normal range. There is as yet no official consensus on these criteria. The APSAC Taskforce recognised in its recommendations that "attachment problems extending beyond RAD, are a real and appropriate concern for professionals working with children", and set out recommendations for assessment. This would significantly extend the definition beyond the ICD and DSM-IV-TR definitions because those definitions are limited to situations where the child has no attachment or no attachment to a specified attachment figure. Boris and Zeanah use the term "disorder of attachment" to indicate a situation in which a young child has no preferred adult caregiver. Such children may be indiscriminately sociable and approach all adults, whether familiar or not; alternatively, they may be emotionally withdrawn and fail to seek comfort from anyone. Boris and Zeanah also describe a condition they term "secure base distortion". In this situation, the child has a preferred familiar caregiver, but the relationship is such that the child cannot use the adult for safety while gradually exploring the environment. Such children may endanger themselves, may cling to the adult, may be excessively compliant, or may show role reversals in which they care for or punish the adult. The third type of disorder discussed by Boris and Zeanah is termed "disrupted attachment". This type of problem, which is not covered under other approaches to disordered attachment, results from an abrupt separation or loss of a familiar caregiver to whom attachment has developed. Most recently, Daniel Schechter and Erica Willheim have shown a relationship between maternal violence-related posttraumatic stress disorder and secure base distortion see above which is characterized by child recklessness, separation anxiety, hypervigilance, and role-reversal. Attachment theory and Attachment in children The majority of 1-year-old children can tolerate brief separations from familiar caregivers and are quickly comforted when the caregivers return. These children also use familiar people as a "secure base" and return to them periodically when exploring a new situation. Such children are said to have a secure attachment style, and characteristically continue to develop well both cognitively and emotionally. Smaller numbers of children show less positive development at age 12 months. Their less desirable attachment styles may be predictors of poor later social development. Because attachment styles may serve as predictors of later development, it may be appropriate to think of certain attachment styles as part of the range of attachment disorders. Insecure attachment styles in toddlers involve unusual reunions after separation from a familiar person. The children may snub the returning caregiver, or may go to the person but then resist being picked up. These children are more likely to have later social problems with peers and teachers, but some of them spontaneously develop better ways of interacting with other people. A small group of toddlers show a distressing way of reuniting after a separation. The ability

to send and receive social communications through facial expressions, gestures and voice develops with social experience by seven to nine months. This makes it possible for an infant to interpret messages of calm or alarm from face or voice. At about eight months, infants typically begin to respond with fear to unfamiliar or startling situations, and to look to the faces of familiar caregivers for information that either justifies or soothes their fear. This developmental combination of social skills and the emergence of fear reactions results in attachment behavior such as proximity-seeking, if a familiar, sensitive, responsive, and cooperative adult is available. These symptoms accord with the DSM criteria for reactive attachment disorder. Appropriate fear responses may only be able to develop after an infant has first begun to form a selective attachment. An infant who is not in a position to do this cannot afford not to show interest in any person as they may be potential attachment figures. Faced with a swift succession of carers the child may have no opportunity to form a selective attachment until the possible biologically-determined sensitive period for developing stranger-wariness has passed. It is thought this process may lead to the disinhibited form. However the innate capacity for attachment behavior cannot be lost. This may explain why children diagnosed with the inhibited form of RAD from institutions almost invariably go on to show formation of attachment behavior to good carers. However children who suffer the inhibited form as a consequence of neglect and frequent changes of caregiver continue to show the inhibited form for far longer when placed in families. Theory of Mind is the ability to know that the experience of knowledge and intention lies behind human actions such as facial expressions. Although it is reported that very young infants have different responses to humans than to non-human objects, Theory of Mind develops relatively gradually and possibly results from predictable interactions with adults. However, some ability of this kind must be in place before mutual communication through gaze or other gesture can occur, as it does by seven to nine months. Some neurodevelopmental disorders, such as autism , have been attributed to the absence of the mental functions that underlie Theory of Mind. It is possible that the congenital absence of this ability, or the lack of experiences with caregivers who communicate in a predictable fashion, could underlie the development of reactive attachment disorder. The two classifications are similar and both include: ICD includes in its diagnosis psychological and physical abuse and injury in addition to neglect. This is somewhat controversial, being a commission rather than omission and because abuse in and of itself does not lead to attachment disorder. The inhibited form is described as "a failure to initiate or respond The disinhibited form shows "indiscriminate sociability The ICD descriptions are comparable. The inhibited form has a greater tendency to ameliorate with an appropriate caregiver whilst the disinhibited form is more enduring. Abuse can occur alongside the required factors but on its own does not explain attachment disorder. Experiences of abuse are associated with the development of disorganised attachment, in which the child prefers a familiar caregiver, but responds to that person in an unpredictable and somewhat bizarre way. Within official classifications, attachment disorganization is a risk factor but not in itself an attachment disorder. Attachment-based therapy children There are a variety of mainstream prevention programs and treatment approaches for attachment disorder, attachment problems and moods or behaviors considered to be potential problems within the context of attachment theory. All such approaches for infants and younger children concentrate on increasing the responsiveness and sensitivity of the caregiver, or if that is not possible, changing the caregiver. These must be designed to make sure the child has a safe environment to live in and to develop positive interactions with caregivers and improves their relationships with their peers. Medication can be used as a way to treat similar conditions, like depression, anxiety, or hyperactivity; however, there is no quick fix for treating reactive attachment disorder. A pediatrician may recommend a treatment plan. For example, a mix of family therapy, individual psychological counseling, play therapy, special education services and parenting skills classes. Attachment therapy In the absence of officially recognized diagnostic criteria, and beyond the ambit of the discourse on a broader set of criteria discussed above, the term attachment disorder has been increasingly used by some clinicians to refer to a broader set of children whose behavior may be affected by lack of a primary attachment figure, a seriously unhealthy attachment relationship with a primary caregiver, or a disrupted attachment relationship. Such lists have been described as "wildly inclusive". Some checklists suggest that among infants, "prefers dad to mom" or "wants to hold the bottle as soon as possible" are indicative of attachment problems. The APSAC Taskforce

expresses concern that high rates of false positive diagnoses are virtually certain and that posting these types of lists on web sites that also serve as marketing tools may lead many parents or others to conclude inaccurately that their children have attachment disorders. These therapies have little or no evidence base and vary from talking or play therapies to more extreme forms of physical and coercive techniques, of which the best known are holding therapy , rebirthing , rage-reduction and the Evergreen model. In general these therapies are aimed at adopted or fostered children with a view to creating attachment in these children to their new caregivers. Critics maintain these therapies are not based on an accepted version of attachment theory. Following the associated publicity, some advocates of attachment therapy began to alter views and practices to be less potentially dangerous to children. This change may have been hastened by the publication of a Task Force Report on the subject in January , commissioned by the American Professional Society on the Abuse of Children APSAC which was largely critical of attachment therapy, although these practices continue.

Chapter 6 : CEBC Â» Search â€º Topic Areas â€º Dsm 5 Criteria For Reactive Attachment Disorder Rad

The criteria for a diagnosis of a reactive attachment disorder are very different from the criteria used in assessment or categorization of attachment styles such as insecure or disorganized attachment.

Chapter 7 : Attachment Theory | Simply Psychology

grant funding in fiscal year ; provided further, that each state entity administering grant funds through this item shall submit a report to the house and senate committees on ways and means not later than February 15, detailing grants awarded through this item and the criteria used for distribution.

Chapter 8 : Reactive attachment disorder - Wikipedia

Attachment. The legal process of seizing property to ensure satisfaction of a judgment. The document by which a court orders such a seizure may be called a writ of attachment or an order of attachment.