



**Tarsha Gale, MA**

## Foster Youth Having Children and the Importance of Relationship-Based Work

Maltreatment and subsequent foster care placement interrupt positive interactions between caregivers and very young children that are critical for creation of stable, consistent, and nurturing relationships. These relationships are the building blocks for children's social, emotional, and cognitive development (Herrenkohl, Herrenkohl, & Egolf, 2003). Infants and young children are the largest proportion of children in foster care in the US (24% according to the US Department of Health and Human Services, 2008). But they are not the only group who suffers from maltreatment and removal from parents.

30% of the US foster care population is over 14 years of age (U.S. Department of Health and Human Services, 2008). These adolescents face many challenges. They are likely to have spent a substantial amount of their lives in out of home placements, may have been in care for years and are at very high risk for poor outcomes because of frequent disruption in care. Each new placement disrupts the youths' opportunity to achieve enduring positive relationships with caring adults and thereby to achieve healthy relationships with others and stability in school and employment opportunities. For example, the Northwest Alumni Study (Pecora et al., 2005) examined 659 adults between the ages of 20 and 33 who had been placed in family foster care for 12 or more consecutive months. On average, these youth experienced 6.5 school placements and nearly one-third experienced ten or more school changes from elementary through high school and almost one-third also experienced 8 or more foster placements.

Unfortunately teen girls in foster care are 2.5 times more likely to become pregnant and have a child by age 19 than those not in foster care (The National Campaign to Prevent Teen Pregnancy, 2006). As mothers, these young women are at significant risk for abusing their own children. However, not all of them will do so. The intergenerational transmission of abuse is influenced by a variety of factors. For example, mothers who experienced more severe physical abuse and had unresolved/unprocessed memories of that abuse may be at an extremely high risk of maltreating their children (Pears & Capaldi, 2001).

While research on child maltreatment for the children of adolescent mothers in foster care is limited, it is reasonable to believe that this risk

is high. These mothers may have experienced severe abuse and neglect and may have unresolved attachment classifications and higher rates of mental illness (Bailey, Moran & Pederson, 2007; Pears & Capaldi, 2001; Pecora, 2005). Moreover, adolescent mothers with a history of abuse who have unresolved states of mind are more likely to have infants classified as "disorganized" and are the least likely to benefit from a video-feedback intervention designed to improve sensitivity (Moran, Pederson & Krupka, 2005; Madigan, Moran, Schuengel, Pederson, & Otten, 2007).

Many programs for pregnant or parenting adolescents in the foster care system focus on teaching parenting skills, promoting education, and becoming self sufficient. However, there is no evidence that the children of participants in these programs show improved outcomes - or even that the adolescent mother was able to keep her child.

Parenting skills, education, and self-sufficiency are not unimportant. However, it is more likely that programs designed to reduce risk factors for adolescent parents and their children will be effective to the extent that they are *relationship based*. Relationship-based programs not only address the parent-child relationship - that is, cultivate a

*Continued page 2*

**Announcing IASA's  
2nd Biennial  
International Conference  
St. John's College,  
Cambridge University, UK  
August 29 - 31, 2010**



## Contents of Fostering Edition

### Page

- 1 Foster Youth Having Children and the Importance of Relationship-Based Work**
- 2 Upcoming DMM Courses**
- 3 Special Review of "The difficult transition to adulthood for foster youth in the US: Implications or the state as corporate parent"**
- 4 Attachment in Action: using the DMM to Foster a Family**
- 5 The Aftermath of Baby P**
- 6 IASA Court Round Table Meetings**
- 7 Second Biennial International Conference**

positive relationship and secure attachment between the mother and her infant – but also promote the development of a positive relationship between the mother and the helping professional (a working alliance).

The research-based premise underlying these programs is that through a positive, stable and trusting relationship with the intervener (providing a secure base for the mother), the mother will be able to experience someone who conveys an understanding of her current situation. This relationship allows her to process and resolve emotional issues related to her past and supports a nurturing relationship with her child. Relationship-based interventions have been shown to improve maternal and infant mental health through a focus on maternal characteristics such as maternal sensitivity, maternal representation of attachment, and insightfulness, all of which aid in the development of a secure mother-infant attachment relationship (Koren-Karie, Oppenheim, Dolev, Sher & Etzion-Carasso, 2002; McElwain & Booth-LaForce, 2006; Schuengel, Bakermans-Kranenburg & van IJzendoorn, 1999).

As infant mental health specialists, we have the opportunity to help adolescent mothers who may never have had the chance to be in beneficial relationships and who do not know how to take advantage of the support and help being offered to them (See Jager, 2008). We may be frustrated by their distance and worried about their infants. However, we have the support of our colleagues and the resource of reflective supervision to nurture us while we help mothers begin to nurture their babies. If our interventions are effective – and there is mounting evidence of what is effective with adult mothers – we have an opportunity to help end the intergenerational cycle of abuse.

**Tarsha Gale, MA, is currently manager of a non profits agency in Michigan working with teens & teen parents in foster care.**

**Ann M. Stacks, Ph.D., LMFT, is an Assistant Professor of Psychology and the Director of the graduate certificate in Infant Mental Health at the Merrill Palmer Skillman Institute at Wayne State University, Detroit, Michigan.**

## References

- Bailey, H. N., Moran, G. & Pederson, D. R. (2007). Childhood maltreatment, complex trauma symptoms, and unresolved attachment in an at-risk sample of adolescent mothers. *Attachment and Human Development* 9, 139-161.
- Elze, D.E., Auslander, W., McMillen, C., Edmond, T., & Thompson, R., (2001). Untangling the impact of sexual abuse on HIV risk behaviors among young in foster care. *AIDS Education and Prevention*, 13, 377-389.
- Herrenkohl, E. C., Herrenkohl, R. C. & Egolf, B. P. (2003). The psychosocial

consequences of living environment instability on maltreated children. *American Journal of Orthopsychiatry* 73, 367-380.

Jager, K. B. (2008). "But I don't trust you" – Recognizing and dealing with parents' history of trauma. In R.E. Lee & J. B. Whiting (Eds.), *Foster care therapist handbook: Relational approaches to the children and their families* (pp.451-467). Washington DC: Child Welfare League of America.

Koren-Karie, N., Oppenheim, D., Dolev, S., Sher, E., Etzion-Carasso, A. (2002). Mothers' insightfulness regarding their infants internal experience: Relations with maternal sensitivity and attachment. *Developmental Psychology* 38, 534-542.

Madigan, S., Moran, G., Schuengel, C., Pederson, R. & Otten, R. (2007). Unresolved maternal attachment representations, disrupted maternal behavior and disorganized attachment in infancy: Links to toddler behavior problems. *Journal of Child Psychology and Psychiatry* 48, 1042-1050.

McElwain, N.L., & Booth-laForce, C., (2006). Maternal sensitivity to infant distress and non distress as predictors of infant attachment security. *Journal of Family Psychology*, 20, 247-255.

Moran, G., Pederson, D., Krupka, A. (2005). Maternal unresolved attachment status impedes the effectiveness of interventions with adolescent mothers. *Infant Mental Health Journal* 26, 231-249.

Pears, K.C., & Capaldi, D.M., (2001). Intergenerational transmission of abuse: A two generational prospective study of an at-risk sample. *Child Abuse and Neglect*, 25, 1439-1461.

Pecora, P. J., Kessler, R. C., Williams, J., O'Brien, K., Downs, A. C., English, D., White, J., Hiripi, E., Roller-White, C., Wiggins, T., & Holms, K. (2005). *Improving Family Foster Care: Findings From the Northwest Foster Care Alumni Studies*. Seattle, WA: Casey Family Programs.

Schuengel, C., Bakermans-Kranenburg, M. J., & van IJzendoorn, M. H., (1999). Frightening maternal behavior linking unresolved loss and disorganize infant attachment. *Journal of Consulting and Clinical Psychology*, 67, 54-63.

United States Department of Health and Human Services (2008). The AFCARS Report: Preliminary FY 2006 Estimates. Washington DC:

**The full article, *Teens and their Babies: The Importance of Relationship Work/The Infant Crier*, 121, 4-6 is available on subscription at <http://www.mi-aimh.org/infantcrier.php>**



**CARE-Index Trainers Course, Key Largo, FL, Nov. 29-Dec. 7, 2010**

**Contact:** Patricia Crittenden pmcrittenden@att.net

**Prerequisite:** CARE-Index Course & Advanced Clinical Seminar(s)

**SAA (in Italian): Reggio Emilia, Italy, Feb. 23-27, 2010, May 15-19, 2010, Sept 21-25, 2010**

**Contact:** Andrea Landini dutil@tin.it

**Prerequisite:** A&P

**Advanced Clinical SAA Seminar: Northumberland, UK, June 11-13, 2010**

**Contact:** Patricia Crittenden pmcrittenden@att.net

**Prerequisite:** SAA Course

**AAI (in English): Reggio Emilia, Italy, Oct. 11-16, 2010, Feb. 21-26, 2011, May 9-13, 2010**

**Contact:** Patricia Crittenden pmcrittenden@att.net

**Prerequisite:** A&P

**Advanced Clinical AAI/TAAI Seminar: Shropshire, UK, Dec. 5-9, 2009**

**Contact:** Patricia Crittenden pmcrittenden@att.net

**Prerequisite:** AAI



**Lisa Mennet**

## Special Review of *“The difficult transition to adulthood for foster youth in the US: Implications for the state as corporate parent”*

*Social Policy Report, 23(1), 3-18. Courtney, M. (2009)*

Optimally, adolescence is the gradual shifting of attachment bonds towards peers and romantic partners with the support of caring adults. Maturing physi-

cal, sexual, cognitive and social capacities compel them to move beyond the confines of the family. However, the process of successful adolescent individuation is much like that for toddlers. For adolescents to individuate, and to flexibly explore their world outside the nuclear family, they must feel safe. This requisite sense of safety comes from a secure base so that the desire for relatedness is balanced by the push to autonomy. Contrast this optimal experience with that of adolescents in foster care. They are often required legally to reach “maturity” abruptly and completely by their 18<sup>th</sup> birthday. That these youths are often ill-prepared for the demands of adult life is documented in “The Difficult Transition to Adulthood for Foster Youth in the U.S.: Implications for the state as Corporate Parent”, Mark Courtney of the University of Washington School of Social Work, reviews recent shifts in the U.S. child welfare system. Courtney calls the research findings on the transition to adulthood for former foster care youth “sobering”. Compared to their peers, these individuals:

- ◆ Are less likely to earn a high school diploma, or go to college
- ◆ Have more health problems and difficulties accessing healthcare
- ◆ Bring few economic resources to independent living, and are more likely to live in poverty
- ◆ Are more likely to have unstable housing or be homeless
- ◆ Are more likely to be single parents with children with health and behavior problems

Courtney suggests that improved outcomes will first require a shift in our thinking about the government's role. The policy goal of the child welfare system has long been to end foster children's dependence on the state by the time they reach majority. Yet the milestones of adult functioning -- completion of education, work and financial independence, and established adult romantic relationships -- are currently achieved by the general population only after a prolonged period of dependency: Young adults commonly rely on parents for some degree of sustained financial support well into their twenties. By severing the care-giving tie early, the state is failing to fulfill its role as “corporate parent,” which “ought to act in ways that are consistent with the ways ‘good’ parents act towards their children...[taking] into account the kinds of support that young people generally can count on during this period of life.” Whilst research is limited, there is evidence that young people who are allowed to remain in care past the age of 18 have improved outcomes on a variety of indicators of self-sufficiency and personal well-being. Hopefully **The Fostering Connections to Success and Increasing Adoptions Act**, which takes effect in 2011, allows youths to remain in care (whether in foster family home, kinship care, or supervised independent living) until the age of 21 provided they are involved in specified educational or

training activities. It includes provisions for continued case management, including helping to develop transitional plans such as accessing education and employment opportunities.

However despite federal support, individual states may remain “ambivalent” about their parental responsibilities. They may falsely fear that remaining in foster care will create excessive “dependence”. Stronger empirical evidence is needed to convince policy-makers and the public that greater investment in services for this population in fact eases the transition to independent living and that the costs borne by society of increased unemployment, health problems, single parenthood, etc., are greater than the costs of providing additional services. Increased case management that coordinates services from other public institutions may be of particular importance. Not only might it help stabilize individuals, it could also draw other arms of government into the role of corporate parent, alongside child welfare agencies. Courtney is hopeful that implementation of the National Youth in Transition Database (NYTD) provisions, which require tracking outcomes for foster youth ages 17 to 21, may help address these gaps in our knowledge.



**As constituents and policy advisors, we should encourage our individual state governments to extend foster care beyond age 18, and to actively assess outcomes.**

As clinicians and researchers, we note the Act's principle of connections over independence, but there is a notable lack of discussion here about the need to protect the continuity of **relationships**. For instance, it is implied that many youths would, under the new Act, move at 18 from a traditional foster home to supervised transitional housing, thus separating them from what may have been a secure base. There may be much to gain by conceptualizing institutions as having a parental role—at the level of populations. At the level of individuals, in this case adolescents with histories of insecure and disrupted attachments, we also need policies that acknowledge and support healthy care-giving relationships whenever they exist.

**Lisa Mennet M.Ed. is a psychotherapist in the University of Washington, Seattle, USA**

For full article see [www.srpd.org](http://www.srpd.org) click 'Youth in Foster Care'





**Mike Blows**

## “Attachment in Action” Using the DMM to Foster a Family

“Sam” was in a hostel. She was 16 years old, alone, and her 2-week-old boy was already in foster care. Although she visited “Kyle” daily, neither her own mother nor Kyle’s father wanted anything to do with him – or her. In fact, Sam’s second foster placement in two years had broken down

just before Kyle was born. Sam was out of school, out of home, and outside of herself with distress and confusion.

The court asked me to assess her parenting capacity – and what I saw didn’t look promising. Sam was passive and hardly responded to Kyle who was unsettled and irritable with her. Nevertheless, Kyle’s foster care manager liked Sam and respected her for coming every day. Because she wanted to give Kyle a chance to have a real mother, she agreed to have Sam move in at least for a period of assessment. This was the break Sam needed. She moved in. (See Crittenden & Farnfield, 2007).

To get a handle on what Sam could and couldn’t do, I gave her an Adult Attachment Interview (AAI). Her AAI set a record for brevity and had lots of dismissing avoidant markers avoiding criticism of her mother; she hadn’t seen her birth father since she was six. Sam said she’d tried to tell her mother about ill treatment by her stepfather, but nothing changed. She’d “battled with” her stepfather when she was 14, then truanted from school and argued with her mother. She ended up in foster care when her mother and step-father were separating. Sam’s bleakness was palpable behind her “not bothered” façade.

I made CARE-Index videotapes including with the foster carer and Kyle. Sam and Kyle’s video was worrying, with Sam very quiet and unable to soothe Kyle. At one point, she let him slip, then banged his head when pulling him to sit. I passed the tape to a reliable coder who provided some hope. The coder echoed the supportive comments of the foster carer. The video revealed that, although almost mute, Sam was trying very hard to make a connection with Kyle, but was rarely able to anticipate his changes of mood. That meant she was constantly reacting to him and only once or twice getting any exchange. The foster carer, by contrast, engaged Kyle easily, but she tended to miss chances to link interactions together and seemed to be looking for a performance from Kyle.

The assessments suggested a range of interventions. Potential for healthy parent-child relatedness was revealed by the Care-Index as well as work to support the foster carer. However we were concerned about the information provided by the AAI and the very minimal contact between Sam and her own mother. Therefore, Sam and Kyle received parent-infant support combined with psychotherapy for Sam. I worked with the foster carer on how to model sensitive interactions with Kyle. Social Services personnel were reluctantly persuaded to support this plan, and Sam was formally “fostered”, but only for 3 months. The consensus was that Sam would opt out of the commitment early on. Sam surprised everyone by engaging and the time was extended to 6 months.

The foster carer bravely agreed to some feedback on her own CARE-Index. By carefully focussing on her positives, she was urged to model more chaining of activities, particularly by giving a running commen-

tary, voicing out loud Kyle’s responses and watching to help Sam start to wonder about Kyle’s changing feelings and interest. At the same time, Sam’s treatment picked up similar themes, but also gently explored why it had been difficult for her mother to play with and at times protect Sam. Despite offers of family work, everyone concurred eventually with Sam’s cautious handling of her own mother.

After 6 months, I repeated the Care-Index. This time, Sam talked to Kyle, verbalising her efforts, which were more contingent. Although still missing Kyle’s interest at times, she was warmer, and this kept Kyle cooperative. This was “crunch time”, and the local authority wanted guarantees that Sam could progress on her own. It felt as though there was haste in forcing Sam toward independence!

Once again the CARE-Index was the tipping point. It indicated that, whilst still mechanical, Sam was starting to use taught techniques. The last video showed Kyle repeatedly returning to a favourite book in his mum’s lap - until she at last discovered the game was to use it as a toy rather than to read! Sam noticed with pleasure how different the mutual joy in this shared moment was from their early relationship. Additionally, Sam’s confidence, and willingness to be more challenged by her therapist and foster carer, helped her moderate occasional antagonism to the social workers. This cooperation in therapy led to a sudden increase in Sam’s capacity to accept support and persevere with Kyle’s coercive responses. Sam still found it hard to handle Kyle’s “difficult” moments, but these were lessening.



Paradoxically, with these improvements the authorities gained the confidence to support Sam and Kyle in foster care for another two years, enabling Sam to complete her education and steadily gain support from her own mother. The foster carer fostered Sam’s new family, the DMM assessments provided guidance about the nature of the difficulties and the way forward, and the professionals coordinated their work around these individualized competencies and goals. To date, in their new and old families, Kyle (now 2) and Sam are still doing well, but the tension to push the mother (only 18) prematurely to independence remains.

**Dr. Mike Blows is a Child Psychiatrist in Suffolk, UK**

Crittenden, P. M., & Farnfield, S. (2007). *Fostering families: An integrative approach involving the biological and foster family systems*. In R. E. Lee & J. B. Whiting (Eds.) *Handbook of Relational Therapy for Foster Children and their Families*. (pp. 227-250). Washington, D.C.: Child Welfare League of America.



**Patricia Crittenden**

## In the Aftermath of Baby P

Since Baby P's death, child protection authorities have been extra cautious, taking more children into care than ever before (Butler, 2009; Dugan & Lakhan, 2008) Does that really protect children? Can too much caution be harmful?

I received this case report in which excessive effort to protect, harmed both the 'protected' child and his caregivers.

Seven-year-old 'David' was removed from his grandparent's home - where he had lived with his 9 and 11-year-old uncles for the four years following his parents' violence to each other and neglect of him. Two conditions prompted this removal. First, his grandmother became exhausted and less able to keep David safe. For example, she let him play outside unsupervised for long periods, even though he sometimes wandered off, and had allowed the three boys to watch violent films late into the night. Preferring to solve her problems herself, she (unwisely) sent her own two boys to her sister while she recovered. The local authority concluded that she was unable to cope. Second, David's teachers reported that he was often tired and had become difficult to manage.

Care proceedings were initiated and David was taken to a foster home quite precipitously.

After placement, David's teachers reported that he became both withdrawn and affectless and also aggressive. The decision to remove him from his grandparents had shocked them; they had wanted to help the family, not precipitate a second move. Now they wished they'd stayed silent. David's foster mother confirmed how upset David was and how much he wanted to return home. David's grandparents felt angry and helpless; they didn't know how to get him back.

When I began working with David, it was clear that the social worker had justified concerns about the grandparents and had been unable to communicate satisfactorily with them. It was also clear, however, that David's life had not been in jeopardy. Was the situation severe enough to justify the harm that removal would cause? The worker had expected a brief respite placement without understanding that most of the damage was done in the moment when the child discovers that he can be taken. Then, as the weeks went by, she became resigned to David's remaining in the care system. She hadn't foreseen that the 'system' is better prepared for rescue than return.

David became more despondent, with aggressive outbursts. His teachers noted his distress after the outbursts, but they didn't know how to understand or comfort him. He swung unpredictably from being gentle and caring to violent and angry.

In treatment, it became clear that David was traumatised by the move from his grandparents' home. His grief, sadness, and sense of futility were almost unbearable. He seemed to be trying desperately to please adults by compulsively caring for his foster mother and complying with teachers and his social worker - but he really wanted to go home.

Using the DMM as a framework for understanding his behaviour, I explained to his teachers and his foster parent how such a 'good boy' could be so 'bad' - and why he felt so ashamed of himself for the outbursts. He used inhibitory self-protective strategies, but sometimes trauma-induced negative affect spilled out violently. This explanation helped to pull their conflicting perceptions of David together. Even so, it was difficult for his social worker to acknowledge the negative impact on David of the stricter policies that had followed Baby P's death. She told me that she had referred the grandparents to a parenting course, but that they hadn't responded. Later I learned that they had attended the course, found it helpful, and had certificates of completion. But the parent trainer had forgotten to notify the social worker.

My opportunity to influence things came when David was allocated a Children's Guardian. She knew the DMM and requested a summary of my work. I outlined how David's behaviour functioned to protect him, how too much inhibition had let his anger become overwhelming such that it intruded aggressively when he felt hopeless. After the court hearing, the Guardian rang to say that my report had helped her to make a strong argument for returning David to his grandparents, together with a package of support services tailored to the family's needs.



**Katrina Robson**

What makes a disaster? It's usually the confluence of many factors. A **context**: in this case, (1) professionals who felt unsafe, (2) grandparents with too many responsibilities and too few skills (sending their own children away), and (3) a child whose life had been disrupted once already leaving him vulnerable to change and uncertainty. **Unexpected events** that set off a **sequence of predictable outcomes** that no one understood: The move of David's young uncles to their aunt probably reactivated the trauma of his move to his grandparents, which exacerbated problems at schools, which alerted his teachers who notified the social workers who were already reeling from Victoria Climbié and Baby P so they acted quickly and strongly - and self-protectively (no 'Baby P' for them!). And **self-protective strategies**: the grandparents' silent independence, the social worker's impetuous rescue, David's compulsiveness. Plus a **breakdown** and a few **mistakes**: David was the weak point; he broke down. The mistakes were miscommunications and failures in communication: from the grand-

*Continued page 6*



parents, from the teachers, and from the parenting service. That's when the services acted self-protectively, pulling David out of a 'dangerous' home, which threw him into trauma and depression.

So who are the bad guys in this sad story? There are no bad guys. The DMM provides a framework for understanding both David's complex behaviour and also the behaviour of all the adults in a way that doesn't blame anyone. If we focus only on the child, we can lose track of other motivations: the teachers', the grandparents', and the professionals'. Only when the big picture is seen and everyone's need to be safe (at home, in school, at work) is understood can a new plan

be made – one that protects everyone.

Butler P. May 9, 2009. 'Baby P scandal leads to sharp rise in children being taken into care' The Guardian: UK.

Dugan, E. & Lakhan, N. Nov. 23, 2008. 'Baby P effect causes rises in care applications' The Independent: UK.

**David is happy now, but his story is a reminder that, unless carers threaten children's lives, children need stable homes and family more than they need 'perfect' homes.**

**Understanding to get the right balance of protection is the key.**



***Every story has a moral. Here's our bottom line:***

**The DMM is about self-protective strategies that we all use. When there is conflict, something isn't known or understood, and, when it is revealed, everyone can become safer.**

**The teachers didn't consider how threatened the services are since Baby P and, therefore, didn't predict how a small complaint could escalate quickly into a care order.**

**The social workers and court didn't understand that even a very short removal does terrible harm to a child's sense of security.**

**Most of the damage of placement is done – and cannot be undone – in the first hour.**

## IASA Court Round Table Meetings

Our first Court Round Table in Bertinoro, in October 2008 concluded that DMM assessment tools would significantly enrich thinking around decisions made in the Courts about children's placements, family contact and therapy. Reports to Care or Private Family Law proceedings usually just rely on live observation and interview rather than using formalised, reliable assessments of attachment.

We met again at Roehampton University, UK in April 2009 to look at what the key aims of IASA should be in taking the model forward within the Legal System. Patricia Crittenden, Steve Farnfield, Senior Lecturer Roehampton University, Angela De Mille, Social Worker, His Honour Judge Peter De Mille – Family Law Judge, Ben Grey Social Worker, Jayne Allam, Forensic Psychologist and Juliet Butler, Child and Adolescent Psychiatrist, attended. Everyone present had extensive experience in assessment and preparation of reports for the Courts.

Judge De Mille provided a "service user" experience albeit a personal view of handling reports, and updated the group on recent UK Law Guidance for Experts Witnesses.

The group saw a place for all the DMM instruments in the Court setting. We noted that for some assessments such as the Care Index, the administration didn't require training, but could be coded remotely or blind. Other tools such as the School age Assessment of Attachment (SAA) and the Adult Attachment Interview (AAI) require training to give the interview. This affects capacity with a limited number of trained DMM interviewers, which needs expanding.

A more significant capacity issue is in coding. Dr Crittenden referenced the attachment literature which has consistently shown that assessments are most effective, coded by coders blind to the history. Reliable coders are limited, especially for the AAI but this too is being tackled through the ongoing training processes.

We tasked ourselves with producing a standard description of the DMM and the assessment tools which would be included in reports. There is already a precedent for this, for example various personality inventories and their validity is described in reports. We hope to reference DMM tools indexed through a link to the DMM website. The standard



description of attachment from the DMM will be helpful for all practitioners who use the model in their thinking, even if they don't include the assessment tools in their assessment process.

The group looked at different reports, which had used different aspects of the DMM. An observational report used DMM thinking but those observations of contact could not be commented on by another DMM expert as they were subjective and not video recorded. It was agreed reports using the SAA and AAI were more robust. The use of the instruments, inclusions of quotations to back assertions and the design of reports were discussed. SAA or AAI transcripts could be appended if used.

The group thought about increasing access to DMM ideas by helping referrers access the model via a list of reliable assessors and coders on the website in the future. The guidance on Expert Witnesses will be helpful. For example anyone providing an opinion to the Court can request feedback, and where DMM tools are used we have a built in user feedback system. The next feedback challenge might be to ask families how they experience the assessment and reporting process.

We met again in June 2009, to standardise DMM assessment descriptions, and plan to publish in the relevant journals to inform and attract referrals. Those of us working with the DMM, see its relevance to real families, and welcome the strengthening of the model for the very rigorous world of the Court system.

**Dr. Juliet Butler is a Child Psychiatrist in Essex, UK**





*Second Biennial International Conference*  
St. John's College, Cambridge University, UK  
August 29 - 31, 2010

**Booking Details in the Next Newsletter and Web Page!**

**An impressive and important presentation of psychological,  
social and biological issues in attachment**

**Our Stellar Plenary Speakers include:**

**Professor Peter Fonagy, UK**

Psychological treatments of Borderline personality disorder

**Professor Michael Meaney, Canada**

Epigenetics on suicide and abuse

**Professor Penelope Trickett, USA**

Longitudinal developmental impact of abuse

**Dr Sverre Varvin, Norway**

Treatment of trauma

**Dr Andrea Landini, Italy**

Integration of all mental health treatments

