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DMM news

The international association for the study of attachment

iasa

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Introduction

IASA is on schedule for establishing its Constitution and preparing an excellent programme for the Conference in Italy. We have slightly rearranged the venue and date to get a fairer deal, to **Bertinoro** (near Bologna) on October 5th - 7th 2008. There will be training courses in Attachment and Psychopathology and CARE-Index before (September 30th - October 4th), and advanced AAI and SAA after (October 9th - 13th). Bertinoro will offer more of a campus feel to the events in a beautiful setting. The first newsletter in October was well received and distributed to folk from over 20 countries in 4 continents.

We value your feedback to **dmmnewsletter@talktalk.net** and would like more news via Andrea's questionnaire about your DMM related activity. We hope you enjoy DMM News and offer some snowy DMM scenes for the festive season.

Mike Blows *Editor* **mikeblows@hotmail.com**

First University programme is in South America!

We are especially excited to be reaching Latin America and have plans for meetings there and for translating our materials to Spanish to reach this huge community. Already Chile has taken the lead by establishing a DMM-based psychology program at the Universidad de Adolfo Ibañez; Steve Farnfield will seek to expand this idea to other universities. We have plans for collaborative activities with other organizations, the first being the UK Ministry of Justice, but others are in the wings with announcements expected in months.

Our Founders Membership is going well with Founders in Europe, North America and South America (see **www.iasa-dmm.org**). The Founders Membership will remain open until our first General Meeting in Bertinoro. We hope you'll consider being a Founder.

With the Founders' support, we expect soon to be able to mount a full webpage, print stationery, and launch our conference in Bertinoro. We already have a new logo and DMM News banner. We're beginning to look like a real organization!

We have a Board of eight based on what we needed to accomplish and who could assist: Mike Blows (UK DMM News), Steve Farnfield (U.K., academic and research issues), Airi Hautamäki (Finland, conference program), Andrea Landini (Italy, conference venue and webpage), Irmie Nickel (Canada, treasurer), Bente Nilsen (Norway, membership), Emilia Sasson (Uruguay, Latin American issues), and me (US chair). Paul Holmes (UK) is helping shape our constitution.

Conference Plans for Bertinoro, Oct 5th - 7th

Most important is our conference in Bertinoro. If you've been there already, welcome home! If you haven't, come see why we love Bertinoro so much and make it your home too. To see what is so special about Bertinoro, check this webpage **www.centrocongressibertinoro.it** Note that the castle has residential rooms for conference participants. Did you ever dream of living in a castle? Come to Bertinoro with us!

The conference will have 4 strands: **(1) Prevention and early intervention, (2) Challenging disorders (autism, ADHD, eating and personality disorders, the psychoses, etc.), (3) Integrating treatment modalities and theories,** and **(4) Forensic issues (both domestic and criminal).**

Because we are an association of clinicians and clinical researchers, we will have a broad range of presentation types. Along with the usual speakers and posters, we'll have **case presentations** (Have you carried out an especially satisfying treatment? Here's your chance to share what you learned with others), **video sessions** (Have you some especially powerful or perplexing videos? This is the place to show them!), **poster discussions** (Here's your opportunity to consider several individual posters on the same topic with the presenters available for questions), and **round-table discussions** (Did you want to hear speakers with different perspectives address the same issues? Propose a roundtable and invite the people you want to hear!). So come to Italy in the autumn and stay a while!

The bottom line is that we are off and running. Projects are popping up everywhere and we'll highlight the best here in the DMM News. Meanwhile, mark your calendar for Bertinoro. Come in October and start working now on your submission for a presentation. Submissions are due by January 31, 2008. Don't be late! We want to include you!

Pat Crittenden

First Program of Comprehensive Training on Attachment Assessment and Intervention in Chile

Priscilla Harcha, Psychologist; Aendrés Benítez, Chancellor of Adolfo Ibáñez University (UAI); Patricia Crittenden; Jorge Sanhueza, Dean of Psychology at UAI; Paola Skoknic, Psychologist; Rafael Macherone, Vice-Chancellor of UAI.

Ten years ago, when we first heard about the Dynamic-Maturational Model (DMM), we knew that it would create a revolution in the understanding of psychopathology, leading to new possibilities for change and prevention.

Since then we have wanted to study the DMM ourselves and to make that possible for others as well. But to make this dream come true we needed institutional and economic support. With Pat's support and that of the Sociedad de Terapia Cognitiva Posracionalista (thanks to Tito Zagmutt and Mateo Ferrer), we continued to have individual courses intermittently between 2000-2006, but we lacked a proper program of training.

It is not a coincidence that our dreams are materializing now. The DMM has reached a level of maturity that has created IASA - and we are creating a university program in the DMM. Pat tells us it is the first anywhere, that Adolfo Ibáñez University (UAI) is both the first in Latin America and also the first in the world to develop a graduate psychology program of specialization in the assessment and clinical application of the DMM.

This three-year program will prepare specialists in attachment research and clinical assessment in a mixed cultural context. The program begins with basic theory about attachment and psychopathology, then moves forward through the different assessments, concluding with seminars on functional formulation and clinical applications in specialized areas (e.g., child protection, institutionalization, adoption). As is true in every country, our teaching materials will be primarily local children and adults, but some dyads from neighboring countries. These materials are in production now for the CARE-Index, the PAA, the SAA, and the AAI.

Our first UAI course, the PAA, was just completed a few weeks ago. The course participants have come from several countries, including Chile, Argentina, Brazil, and Uruguay. The reliability test will begin in January after the DVDs come back with our delegates to the Advanced Clinical PAA Seminar in Key Largo.

We are excited to be beginning this journey and eager to use our knowledge and skills to improve the quality of life of children and families in Chile and our neighboring South American countries.

Pat, thanks for making the dreams of many come true...

To UAI, for believing that it's possible and establishing our program...

Paola Skoknic S.
Priscilla Harcha A.

Learning the School-age Assessment of Attachment (SAA)

Few of us knew, when we began the SAA course organized by Steve Farnfield in Portsmouth, that we were taking on an experience that would evoke childhood memories of tests, parsing sentences, and grammar, not to mention personal family memories! We were the 4th course (after Sydney, Reggio Emilia, and Barrow-in-Furness). Like other DMM assessments, the SAA is hard to learn and requires Pat's '9 Layers of Learning', plus a good restaurant or two. But we survived and have a fresh view of children's problems. If you are interested, the next new SAA course will begin in Portsmouth in June, 2008).

The SAA consists of 7 picture cards showing increasing levels of threat that a school-aged child could potentially face. The interview protocol asks for an imagined story about the child on the card and then for any similar memory from the child's life. For each story, the child gives the sequence of events **(cognition)** and their feelings **(affect)**, the child's thoughts about attachment figures' thoughts and feelings **(perspective-taking and theory of mind)**, and reasons why the child did what he or she did and ideas about what they might do in the future **(concrete reflective functioning regarding the self)**. The interview is taped, transcribed and then annotated for specific discourse markers in each of six memory systems. These are derived from the DMM method for the AAI (Crittenden, 1999) and adapted to fit the speech patterns of school-aged children. Using written guidelines, each SAA protocol is assigned to one of several DMM classifications. The child also draws the family and the parents give a brief history of life events.

Similar to the AAI, the SAA identifies unresolved trauma and loss (U's) as well as modifiers (depression, reorganisation, disorientation and intrusions of forbidden negative affect.) Death or loss of a parent can have devastating consequences for children, especially when the adults' mental health and personal needs are in conflict with children's. For example, after the loss of a spouse, the surviving parent may need to mourn and then move on whereas the child must re-integrate the loss of their parent again and again as development changes its meaning to the child.

In addition, children are vulnerable to taking on the unresolved traumas or losses of their attachment figures, and treating them as their own. This may present as vicarious, displaced, or anticipated lack of resolution, with associated distress, even though the children themselves have had no experience of the actual event. Resolution of trauma in childhood is dependent on the safety, protection and comfort offered by the child's attachment figure and their ongoing availability for explanation and reflection.

Because the U's in the SAA are not as specific as those in the AAI, it is essential to interpret the SAA in the light of other information regarding the child's and parents' history.

The SAA offers a much-needed standardized, reliable and informative assessment of 6 - 12 year old children. The format of using pictures rather than toys appeals to this age range and is replicable. The SAA provides pertinent information on (1) children's self-protective strategy (i.e. why they do what they do when they feel threatened), (2) the sorts of stressors that are most troubling to them, and (3) how they process information to

organize their behaviour. Knowing the strategy is helpful for parents and professionals. Knowing the stressors helps everyone to prevent problems. Knowing how children's information is processed (especially when combined with discourse analysis of their attachment figure's AAI) is crucial in distinguishing apparent strategies from actual psychological and behavioural processes. This will greatly assist mental health professionals and parents to select helpful treatments (and avoid inappropriate ones).

The members of the Portsmouth group had many ideas about applying the training to their work. These include court assessments, working with foster carers and with children in care, exploring the functioning of groups such as those on the autistic spectrum and allocating therapeutic resources appropriately, based on children's assessment profile.

The group will meet again in April 2008 and there will be an advanced SAA after the conference in Italy in October 2008. **Angela de Mille, Emma Higgs (UK), Catherine Thomas (RSA),** and **Julet Butler (Eire),** all currently work in the east of England.

Exciting DMM Research in Progress: Validation of the School-age Assessment of Attachment (SAA)

Last year, we were invited by Patricia Crittenden to gather data in Barrow-in-Furness, U.K., for a study to validate the SAA. Pat wanted to know how the SAA related to the already validated PAA. We wanted to test whether the DMM could inform our practice locally with children and their families as well as evaluating what we do.

Our research focuses upon two types of validation: longitudinal (from late pre-school to early school years) and concurrent, i.e., from the SAA to child diagnosis and other clinical measures such as anxiety, life events, and current parent functioning.

The hypotheses for the study are that a) children's PAAs will be related to their SAAs, b) children's PAAs and SAAs will be related to the mothers' AAIs and other clinical measures, c) children in the normative group will more be often classified as B, A1-2 and C1-2 than those children from the clinical group, and d) children from the clinical group will more often be classified as A3-6, C3-6 and A/C and also be more likely to have modifiers of depression, disorientation and intrusions in addition to unresolved losses and traumas.

We will assess at least forty children and their mothers, half normative and half clinical or in risk conditions, e.g., child protection, treatment, and foster care. We begin with a Preschool Assessment of Attachment (PAA) with the child and mother when the child is between five and a half and six years old, an AAI with the mother and several questionnaires. Six months later, we administer the SAA to the child and complete a few more questionnaires.

As a researcher, Pat has focused on methodology and threats to validity. As practitioners, we have been careful to ensure that the study is embedded in and supported by our local community. This, we think, constitutes the right mix for clinical research. The local professional network and the families who have participated have been enthusiastic and open to learning and we proudly hosted the first British SAA training earlier this year.

Involvement in this research has been a constant process of doing, reflecting and learning fast. Finding a normative sample has been a challenge and we have refined how we do this to avoid parents self-selecting. We found that the most interested parents were often those with problems that they hoped, in an inexplicit way, we might find or ameliorate. We are adapting our procedure to access all parents of children within the age range and seeking their consent for us to approach them - instead of asking them to contact us.

The assessments have been fascinating, opening a whole new way of conceptualising and understanding children's difficulties. Being able to directly observe a balanced child in relationship with the parent (PAA), and then in relation to the interviewer (SAA), and also have an opportunity to understand the parent's history and functioning (AAI) has provided us with a rich and exciting learning opportunity. Our understanding of the interconnectedness of family members increases with each case that we see.

Our first normative family followed the completion of four clinical PAA's. The quality of the relationship and warmth between 'David' and his mother shone through and contrasted significantly with the troubled dyads we had seen. This provided a reference point that clinicians often lack. Despite this, there was an ordinary feel to this PAA and we were reminded of the baby/mother dyads which Pat shows on the A & P course and her caveat that we are not looking for perfection. Undertaking the AAI with 'David's' mother and then his SAA at 6 years of age provided further reflection. It was fascinating to see how issues raised in the mother's AAI were also raised by 'David' in his SAA.

We also learned from 'Jenny' and her mother, known to Children's Mental Health Service for some years. The most striking aspect of her PAA was her mother's extremely flat affect and its impact on 'Jenny.' Having learned the discourse markers that correspond to the attachment patterns, we were saddened to see how hard she tried to answer all the SAA questions and the energy that it takes to be compulsive.

Observing dyads from our own area with all the idiosyncrasies that are peculiar to Barrow (and ourselves) has been interesting and we apologise to all you DMM'ers who will see our PAA's and struggle to understand the accent!

We are very keen to use our study to provide learning for the professional community around us and are hopeful that this will influence services provided to children such as 'Jenny', enabling professionals to view families' experience in a new way, to have empathy for both child and mother, and to intervene helpfully with the **dyad** rather than the child alone. The mothers involved are very keen for feedback and this will be an important part of what we do: providing feedback when things are going well, as they are for 'David' and his mother and helping mothers to understand when their child is having difficulties.

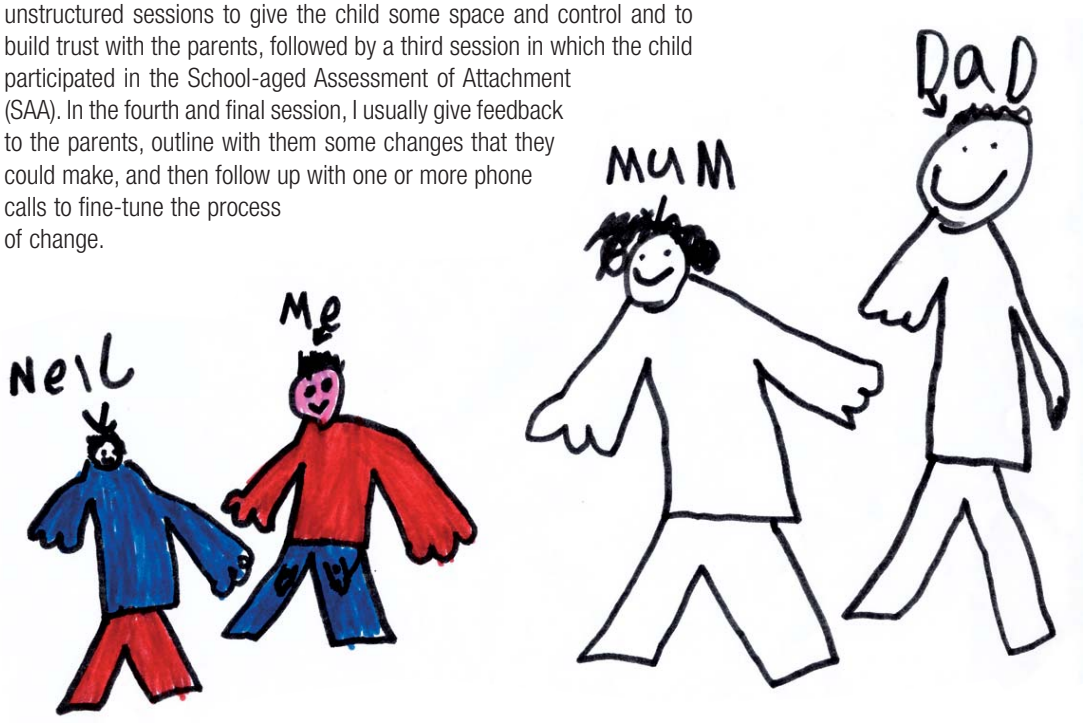
We are privileged to be in a position where we can apply what we are learning to support real children and their families in our community. As Pat has pointed out in our first DMM News, we are lucky enough to be part of an organization which is striving to provide sound and rigorous research which can address theory, assessment and clinical applications. We hope that our study is a step towards "fulfilling the dream of transforming the way treatment is conceptualised and delivered."

Alison Tooby & Trina Robson

Brief Treatment of a Type C Child - Using the SAA

Toby's second grade teacher had raised the alarm after he bit a school friend on the ear! Toby and his parents had seen several clinicians previously and attended parenting courses without change.

In an introductory session, I explained my usual practice of two unstructured sessions to give the child some space and control and to build trust with the parents, followed by a third session in which the child participated in the School-aged Assessment of Attachment (SAA). In the fourth and final session, I usually give feedback to the parents, outline with them some changes that they could make, and then follow up with one or more phone calls to fine-tune the process of change.



In the first two sessions, it became clear that Toby's parents had different ideas about raising Toby, and he was struggling to know how to please them both. I saw little of the aggression that had initiated the referral. In session three, Toby engaged eagerly in the SAA, but spoke with lots of repetitions, queries to me about what to say, and uncertainties in the stories about how problems could be solved. In both discourse and content, Toby's SAA suggested that he used a feigned helpless strategy (C4) of anxiously waiting for powerful people to show him what he should do and even feigning helplessness and letting others act for him. This made him both anxious and angry.

Before telling his mother this, I gave her written descriptions of the DMM strategies (cf., **www.patcrittenden.com** home page). When she picked the C4 strategy for Toby, we moved quickly to discussing how we could change it. I pointed out that Toby's uncertainty about what his parents wanted was key. Using this idea, we sought likely scenarios where the absence of clear 'rules' might give him stress. We pinpointed bedtime management as an example to try to change. Toby's parents worked shifts and handled putting Toby to bed differently, which confused Toby. With discussion, his parents came to understand that consistency was more important than either approach. They agreed on a plan and began to implement it.

Two weeks later, Toby's parents (and the school) reported that his symptoms had calmed. Toby's mother had gained enough confidence to generalize the idea of consistency, identifying inconsistency in her husband's yelling at their youngest child while she took a milder, more sympathetic stance. They each modified their behaviour with Toby's brother so as to prevent problems. Follow up sessions were used to consolidate Toby's sense of self esteem, particularly by helping him to identify and express more accurately how he felt. This, combined with his parents' greater attention to his communication and more consistent responses to him, enabled Toby to engage more directly in both learning and play with his peers.

This case shows how the DMM increased the accuracy of a behavioural formulation and enabled the parents to make rapid, simple, and effective changes - that had been impossible when the focus was on reducing Toby's aggressiveness.

By contrast, if Toby had shown an affect inhibiting 'A' strategy, the focus of treatment might have been on the parents identifying and giving explicit expression to the child's negative feelings - without disapproval. In addition, they might have been guided to use more reflective listening to see below the surface of their child's overly compliant or too cheerful behaviour. In more extreme cases, when Type A children experienced intrusive explosions of distress, they would have been taught to help their child to accept and moderate negative feelings. That is, rather than working toward consistency and clarification of mixed feelings (as with Toby), the therapist might focus on helping the parents of a Type A child to identify and accept their child's negative feelings, using expression of these to help them to adapt their own behaviour to their child's needs and preferences.

Carolyn Rolls,
Australia

For two published studies that show the breadth of the SAA for clinical application see: **Crittenden, P.M., & Kulbotton, G.R. (2007). Familial contributions to ADHD: An attachment perspective. Tidsskrift for Norsk Psykologorening, 10, 1220 -1229.**

Go to **www.psykologforeningen.no** and click Tidsskriftet - 10/07.

Kozlowska, K., Foley, S., & Crittenden, P.M. (2006). Factitious illness by proxy: Understanding underlying psychological processes and motivations. Australia and New Zealand Journal of Family Therapy, 27, 92 - 104.

Copies available from the authors.

Conference Report: Forensic Applications of Attachment Theory

A landmark conference examining the potential uses of the DMM in prisons and probation took place in Portsmouth, England on 1st October 2007. Professor Graham Towl, the Chief Psychologist of the UK Ministry of Justice, and Dr. Patricia Crittenden convened the conference.

Professor Towl described the state of offender rehabilitation in the UK, noting the heavy reliance on cognitive-behavioural therapy and its limited results and methodological rigour. He called for improvement in both treatment and research, in particular, in how therapeutic responses could be shaped to individual needs, based on understanding the individual's strategies.

Recent changes in the Ministry of Justice in the UK create an opportunity to take a new approach with offender rehabilitation, especially younger offenders and young people in care. Professor Towl is keen to explore ways to integrate the DMM with forensic work. He emphasised the importance of well-founded theory and high-quality research, then introduced Dr. Crittenden.

Dr. Crittenden outlined the basic principles of attachment theory as applied to forensic settings and then offered a strong case for why we need a new theory to underpin therapeutic practice. She cited meta-analyses of treatment outcomes that show treatment to be only 15% more effective than no treatment. If this is balanced against studies showing that psychological treatment is detrimental to patients in approximately 15% of cases, it appears that the benefits and harm of treatment cancel each other out.

Dr. Crittenden then raised several questions: Are we delivering treatment to the wrong people or at inopportune times? Are we offering it in the right amount? She advocated clustering individuals by their self-protective strategies and patterns of information processing and proposed using assessment of these to fit treatment to each individual.

She then offered a number of principles for attachment-informed treatment:

- Establish safety in the therapeutic relationship.
- Develop a unique & respectful relationship where the therapist understands how he or she may function as a transitional attachment figure (i.e., potentially the first person to see the client accurately as a person).
- Help the client to develop observational skills (including self-observation).
- Help client to repair maladaptive strategies, including addressing depression, intrusions of negative affect, and unresolved trauma and loss.
- Help client to access omitted information.
- Help the client to differentiate safety and danger.
- Help client to expand the array of strategies, including strategies for recognizing safety.
- Help client to generate and improve reflective functioning.

Peder Nørbech outlined his research and therapeutic work with violent offenders in Norway. One technique mentioned was behavioural self-calming through stretching and breathing. Peder focused on the important role of DMM theory in his work. He outlined his hypotheses regarding how the AAI may relate to the Psychopathy Checklist (PCL-R), and how intrusions of negative affect in the AAI may be indicators of a propensity for explosive, non-strategic forms of violence.

Dr. Valerie Hawes, Psychiatrist at HM Prison Whitemoor, described the research and treatment programme for male prisoners with severe personality disorder. She emphasized the usefulness of the DMM, stating that it leads to greater understanding of offenders.

In the afternoon, Dr. Crittenden spoke briefly about the need for sound forensic research. She offered a hierarchy of increasingly precise (and correspondingly expensive) studies. Then several small groups met to explore issues around funding, infrastructure and research. Professor Towl suggested options for funding research and pilot projects.

The conference closed with enthusiasm for carrying the ideas forward. Professor Towl encouraged the IASA Forensic Applications Committee to formulate and submit proposals.

Clark Baim cbaim@hotmail.com

Simon Wilkinson invites you to check these papers out...

Two recent papers by authors well versed in DMM look at the self-protective strategies of women with eating disorders:

1 **Zachrisson, H. D., & Kulbotten, G. R. (2006) Attachment in anorexia nervosa: An exploration of associations with eating disorder psychopathology and psychiatric symptoms. Eating Weight Disorder, 11, 163-170.**

All 20 patients were classified as 'insecure' based on classified AAIs, with high rates of unresolved trauma and losses. This supports previous reports on anorexic patients. The authors considered whether the stress of the eating disorder contributed to the insecurity.

2 **Ringer, F., & Crittenden, P. M. (2007) Eating disorders and attachment: The effect of hidden family processes on eating disorders. European Eating Disorders Review, 15, 119-130.**

This study compared the DMM attachment (by AAI) in 62 women with anorexia, bulimia, or anorexia with bulimia to determine their self-protective strategies and differences in these by type of eating disorder. All the women had extreme difficulty in talking about themselves, their family, and their childhood. Discourse analysis indicated that the groups overlapped, but differed somewhat in strategy and extremeness of strategy: C3-6 (bulimia), A3-4 (anorexia) and A/C (purging anorexia). There were no A5-8 or C7-8 strategies.

This fits the clinical impression that these families, though in trouble, were striving hard to protect their daughters.

Content analysis suggested that lack of resolution of trauma or loss among the mothers (but unknown to the daughters) or hidden conflict between the parents was likely. These were kept hidden on the erroneous belief that this would protect the daughters from the mother's distress. Instead, it elicited (1) life-threatening strategies for generating parent-child contingency and (2) vicarious or imagined unresolved trauma. The authors suggest that awareness of the hidden information could inform dyadic and family treatment by helping families to disentangle their daughters from parental issues, thus ending the daughters' desperate struggle for predictable effects in their relationships. A central treatment issue would be revealing the daughter's distress without making their very vulnerable mothers feel that they had failed. The authors recommended further validation by comparison with other diagnoses.

If you access these potentially seminal papers in full and review them rigorously, I feel sure they will stimulate your own ideas for treatment and for further investigation on clinical topics.

Did you know that the solid foundations of Attachment are honoured by mountains? Happy New Year!