JUN 08

DMM news

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The international association for the study of attachment

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Contents

Introduction

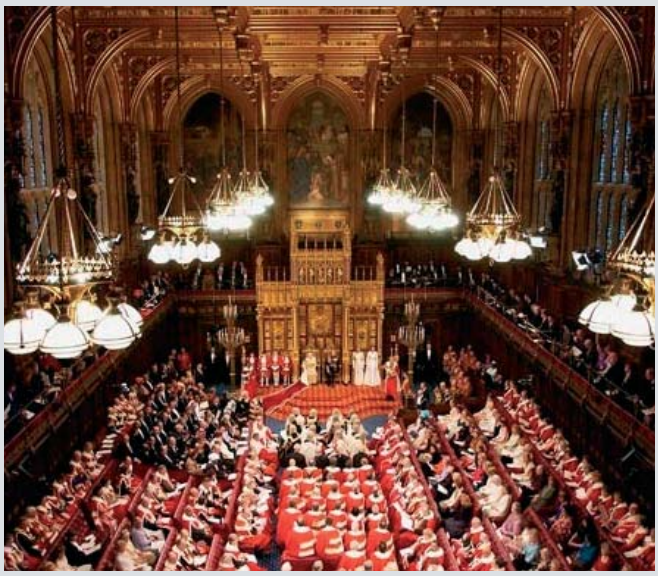
Our 3rd newsletter focuses on early prevention and intervention. Our contributions range from setting up services to case studies. These and the erudite review of Kasia Kowlowska's elegant paper on conversion disorders show the potential of the DMM to help understand complex difficulties and guide treatment.

Pat Crittenden reports on her opportunity to influence policy in the UK which is currently struggling in Europe with relatively high rates of difficulties for young people.

Our members list is growing, see our new website **www.iasa-dmm.org**

The 4th newsletter in June features 'sex and violence'. Please contact Mike Blows if you wish to contribute or have a late offer of a poster for Bertinoro in October.

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



The DMM goes to Parliament

On April 1st, I visited the UK Parliament to talk to political leaders about social policy for children and families. I was blown away by the grandeur of the House of Lords and by everyone's commitment to improving conditions for children and families and by their eagerness to hear what our Dynamic-Maturational Model (DMM) of attachment and adaptation could offer.

First, a few facts (from the Breakdown Britain and Breakthrough Britain volumes): The UK has the lowest rate of marriage in the EU. Cohabiting parents are twice as likely to separate as married parents with 8% of married couples and 43% of cohabiting couples separating by the time the oldest child is 10 years old. Children not living with both biological parents experience more educational problems, substance abuse, and psychological/behavioural problems in childhood, and unemployment and debt in adulthood than children with both parents in one home. Cultural subgroups differ widely in their support and use of marriage.

This is why I am pro-marriage. Marriage is good for children and children are our future. We need policies that support marriage.

So what did I suggest to UK's policy leaders? I offered a brief set of ideas and recommendations:

1 **One size doesn't fit all:** We need a wide range of services to fit the varied needs of children and families. (a) Intensive, personalized, & managed services to very high risk families that already have evidence of dysfunction, e.g., teen parents, drugs, crime, etc; group prevention services might be harmful & are wasteful to these families. (b) Group preventive services to moderate risk families in which there are conditions associated with dysfunction, such as low income, poor education, but not yet dysfunction. (c) Brief services, e.g., short-term counseling, to adequate families facing a one-off crisis (sudden death, job loss) without generalized risk. (d) No prevention services to low risk families: the confidence of 'good enough' parents can be undermined by unnecessary services that waste precious resources.

2 **Support all families while encouraging strong family structures:** Create policy to (a) reward marriage, (b) provide unlimited services to biological families rather than to foster care, (c) encourage poorly educated women to delay childbirth and well educated women to accelerate childbirth (thus aiming for the 20's when women's bodies are maximally prepared to bear healthy children), (d) design neighborhoods to encourage adults, including grandparents, to be visible and children to be free to play safely outside.

3 **Organize interventions to address developmentally salient issues:** especially early infancy, toddlerhood, and the transition to adulthood. Start where the individual or family is, not where we think they need to be; this is especially important in cases of child protection. Most important: Combine child, adolescent, and adult services (and training) as Human Psychological Services. Why? Almost all troubled parents had troubled childhoods and all children need parents.

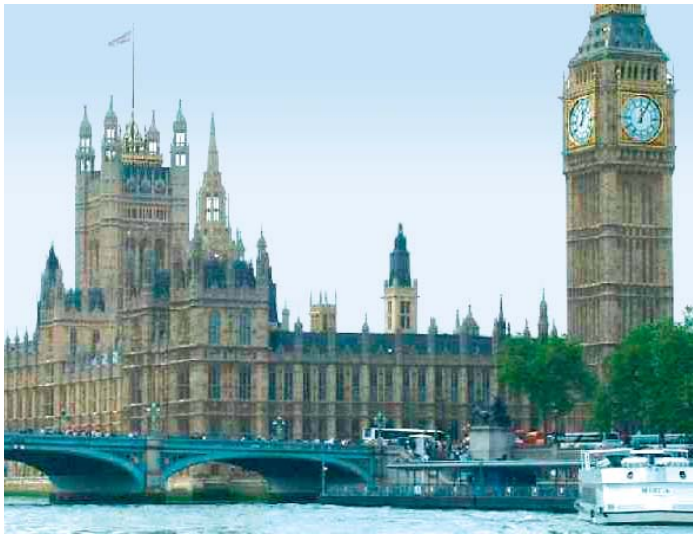
4 **Structure interventions to do as we want families to do:** For example: (a) interventions should be less didactic, more responsive, (b) interventions should not be imposed; choices should be offered, (c) parents should not be accused; they should be understood and supported, (d) the process should be reciprocal & respectful and without name calling ('abuser', 'molester', 'psychotic') or bullying (threatening to place children in care). I suggested that power misused begets the misuse of power.

5 **Avoid the slick, superficial, and strident; avoid fads in treatment:** I said that it takes 2 decades to raise a troubled parent; we cannot undo that in 12 easy, manualized lessons. I pointed out that early prevention/intervention is not an inoculation against the future so we must be prepared to follow up on a good start. Finally, I argued that we lack an adequate evidence base because (a) the goals that are tested are not deemed important by many psychotherapists, (b) many studies are biased because they are done by people wanting to support their treatment, (c) negative findings are not published, and (d) evidence of harm is not sought.

Similar policy work is being done in Canada, both on services for children in general and on services to Aboriginal communities to help them recover from generations of policy that harmed their families. Because of the recent separation of Aboriginal service structures from existing service structures, Canadian Aboriginals have an almost unique opportunity to institute the best policy without being hobbled by the past. More on that later!

The DMM is open for business! We want to help troubled individuals, threatened children, and families of all types. We're prepared to travel anywhere and talk to anyone about how to help people to live happier, healthier lives. If you have connections to policy makers or service administrators, we'd like to hear from you!

Meanwhile, I'm still agog over going to the House of Lords, having tea with Baroness Morris of Bolton (chief whip in the Lords and Shadow Minister for Children), meeting Ian Duncan Smith, and sitting right in the House of Lords. In a twist on an old western sitcom line: "Have theory; will travel!"



Reply to Pat

Dear IASA,

Why I needed you.

Our policy group, which represented all Children's Departments and included senior MP's,were bowled over. Amazing!

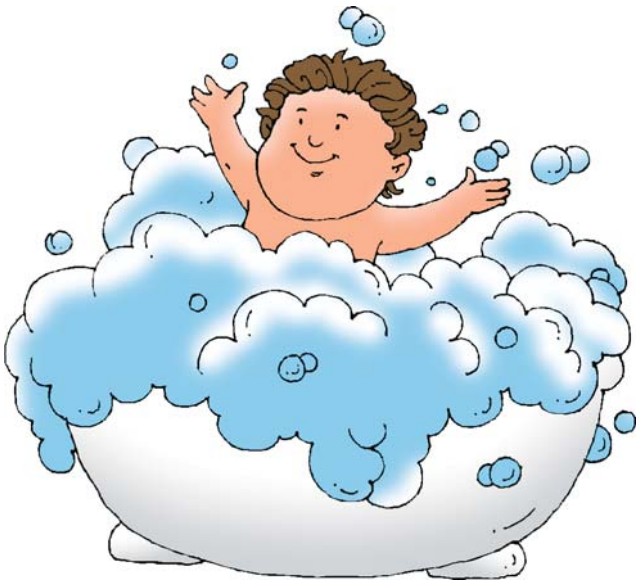
The DMM represents a model that is actually far more acceptable and understandable to policy makers, as it refelects the developmental pathway of an individual and the environment they live in. Previously there has been a viewpoint that attachment patterns were pretty fixed in all cases, promoting an idea that ultimately there's nothing that can be done to help many vulnerable people in the way most psychologists / therapists would like and therefore 'global' answers to psychosocial problems would be the most logical solution. Showing the individuality of dyads,encompassed in the individuality of each culture is dramatic and shocking. It means WE CANNOT ASSUME that there are easy cheap answers. It also shows vividly how easy it is to inadvertently disrupt attachment, instead of the view that only active and dramatic abuse causes problems. Politicians can no longer focus on the belief that poverty is the only significant cause of national distress. Using the DMM could challenge the slide to 'one size fits all' and allow us to attempt what is actually needed.

The dyad films both shocked and amazed, as people actually see what should happen between a baby and parent, when they gaze into each others eyes. They were especially interested in the ideas around fostering. Seeing for themselves blew all sorts of assumptions away, and yet that film needs to be seen by journalists who influence the nations' perspective to the extent that babies are seen as a big chore that costs lots of money.

The power of film is incredible. I think everything was summed up by a researcher from the Centre for Social Justice when she said, 'I'll never look at a baby and its mum in the same way again'. Perfect.

Melanie Gill

When a baby is thrown out with the bath water, does anyone hear it scream?



The English expression 'throwing the baby out with the bath water' gives the image of a carer so focused on the process of cleaning that they inadvertently toss away not just the dirty water but the treasured, sparkling clean baby too. Babies are messy, runs the metaphorical sub-text, cleaning them is a seemingly endless task, scrub them well enough and they will be clean forever. But at what cost?

Reflecting on what is happening around parenting programmes currently in the UK, an equivalent metaphor may be taking place. A few people with influence are promoting that we know which programmes do and don't work. We should they argue, only offer parents a few clearly identifiable, effective, 'evidence-based' programmes. Only these are powerful enough to teach parents skills that can reduce the risks to their children. Only these are cost-effective. Only these can make the necessary changes to improve the quality of parenting. It's time, they say, to 'pull the plug' on all the ineffective programmes.

This generally means that the retained programmes are behaviourally based, require group-based rather than individual delivery, last little longer than 8-12 weeks, come in glittering off-the-shelf packages and have been evaluated using randomised controlled trials. These packages have been developed for,and tested on parents in countries outside the UK, rarely extensively, and not always on parents with comparable needs. Even so, the arguments run, they are so well tried and tested they continue to receive government funding. Unhelpfully, very little research funding has been put in to see whether these programmes work in the UK context.

The main factors underpinning this situation are:

- Muddled thinking about the aims and objectives of parent support programmes leading to conceptual confusion associated with the testing of outcomes.
- Lack of understanding of the scope of evaluation designs underpinned by inadequate training in, and experience of research methods among those in strategic positions.
- A lack of commitment to research, resulting in a widespread failure to gather the evidence needed to assess the effectiveness of UK-developed interventions.
- The false assumption that all assessment techniques designed for use within clinical settings can, and should be applied, without modification, to interventions in other settings.
- Belief in simple solutions to complex problems.

All these factors, and more, have led to flawed evaluations of interventions, to misguided conclusions and, ultimately, to unsafe policy decisions (Barrett, 2007). They seem set to initiate a savage pruning of parent support services that will leave the most complex interventions starved of resources.

There is currently no common agreement about how parenting interventions might best be evaluated or about what should count as evidence of effectiveness. It is easier to produce hard evidence of effectiveness when programmes have only a few behaviourally defined aims, such as teaching specific techniques to manage challenging behaviour, e.g. to praise and reward more and to ignore bad behaviour. At core, most programmes teach these techniques. It is much more difficult to demonstrate effectiveness with programmes that offer befriending services to parents (Newpin, Pippin) with widely varying needs, sometimes to complement more intensive interventions. These can offer multi-layered support (practical help, a meeting place, short skills-training courses, a sort of 'second home' where parents can learn to 'find themselves'and where they can begin to feel safe enough to think more reflectively) to parents with complex and enduring problems, often experiencing domestic violence, social anxiety and isolation, depression and anxiety, as well as at risk of abusing their children. Progress can come in many forms, including agreeing to relinquish care of children. Standardised measurement tools are unlikely to capture the variety of subtle yet important shifts that these kinds of support can produce.

Systematic evaluations of many UK-developed parenting interventions (e.g. health visiting services) have not been funded. As a result, we have no substantial evidence of either their effectiveness or their ineffectiveness. But it is not true to say that programmes developed on a more commercial basis in other countries have been proven to be more effective. We simply do not know. The comparisons have not been made. By dispensing with more complex interventions in favour of simpler, neater solutions, we may well be throwing baby out with the bath water.

Helen Barrett, President, International Attachment Network (IAN)

Barrett, H. (2007) Evaluating evaluations (of Home-Start, Sure Start and Primary Age Learning Schedule). London: Family and Parenting Institute.

Reply from Pat Crittenden

I agree Helen. Although the comparisons have not been made, we do know however, that standardized programmes give up the excitement that comes from professionals working directly with parents to create the programme that meets the parents' needs. The process of attunement might be the critical component of the intervention, because it is what very troubled parents missed in their own childhoods and can't (yet) offer to their children. By dispensing with diversity, we may fail to meet the needs of diverse families. By failing to fund programmes with more complex interventions in favour of simpler, neater solutions, we may, as you say, be failing to meet the needs of families with complex problems.

Crittenden, P.M. (1991). Treatment of child abuse and neglect. Human Systems.2,161-179

A 'strategic approach' to a multi-level system of parent-infant intervention in Ireland

Our Community Child Psychology service typically takes traditional cases with ever increasing demands for family crisis interventions. However we were also asked for prevention and intervention work for early relationship difficulties, and knew that our services for these families were struggling to achieve the desired outcomes.

Developing such work with limited resources in public services is a challenge. The DMM principles offered the theoretical foundation that stood out for us among the research literature and best practice models. After a 5 day Attachment & Psychopathology course, we were excited by the insight, relevance and hope, that the DMM offered in potential work with families, particularly during the early critical period for change.

We wanted an inclusive programme for all mothers and infants, from dyads where problems are clearly formed, to those who just seek information on promoting their infant's development. The CARE-Index,(training by Steve Farnfield in Portsmouth) was the key assessment and intervention tool to develop such a programme. We then we met with 'PO' Svanberg in Newcastle, whose experience of its use and his evidence of the positive effects of attachment-promoting programmes and how to prioritise resources for this critical period, was inspiring.

The presented rationale for 'Prevention and Early Intervention Work with Parents and Infants'.

- "Treating Mental Health is expensive but leaving mental health untreated is more expensive and a luxury that most nations can ill-afford." WHO, 2005.
- Economic analysis shows that returns are highest for investments made at younger ages; the optimum investment profile declines with age (Heckman & Masterov, 2007)
- Evidence-based research clearly demonstrates the cost-effectiveness of attachment promoting programmes with primary carers and infants (Svanberg, 1998; 2007).

We used this to argue with senior managers the priority for a psychologically minded programme to promote infant attachment relationships. Once informed, our colleagues at all levels readily supported efforts to expand services with the best outcomes.

A systematic and strategic approach to infiltrate current medically focused care, enabled us to continue to target service managers in prioritising this area of public service work, but also deliver a) an individual psychology service to parents and infants to create a 'secure base' and resilience, and b) collaboration with other health service professionals promoting infant development as well as liaison with other psychologists in Ireland working similarly.

Rather than wait for resources we took a graded and phased approach towards delivering a local universal and progressive service (September 2007) with a key community group. This gradual accommodation of existing roles and duties insured against the project faltering.

Phase 1 (completed!) aims

- Provide Psychological Consultation to augment the existing Maternity and Infant Care and Family Support services within the Irish health care service and
- Target, Prioritise and Promote the foundations of early Relationships.

Method:

- Consultation meetings with Regional Nursing Directors. (N=4)
- Consultation and education forums with all Public Health Nurses (N=60) in the region, on the new mother-infant programme.
- Advising Professionals, for example, GP's, PHN's, Social Workers, Primary Care Workers, Adult Mental Health teams, on identifying parent-infant dyads who may benefit from existing appropriate psychological and mental support services.
- Prioritised referrals received of parent-infant dyads in need for immediate assessment and intervention (20 referrals received in the first week!)
- Integrated and delivered additional psychological component into existing Ante-Natal programme: "Promoting Psychological and Emotional Development of Infants and Parents: Learning about how Babies' minds work and Promoting their First Relationships"

Goals of Direct Psychologist Intervention with Parent-Infant Referrals/Ante Natal input:

- Engaging parents and families in accepting help.
- Improving awareness of Infant Development.
- Addressing past and present parental psychological issues.

Goals of Indirect Psychologist Intervention through Multi-disciplinary Consultation:

- Emphasising key concepts of attachment and parent-infant relationships.
- Integration promotion of these concepts into professional's daily practice.

Phase 2 now aims to:

- Build on Phase 1 and introduce DMM theory to professionals working with families, to educate them on attachment promoting programmes.
- Educate more professionals on how they can integrate parent-infant focused work into their current practice.

Continued on p5

Continued from p4

These aims, we will achieve through:

- A 2 day "Introduction to DMM Conference": to health service clinicians and managers, across the locality and the country, by Dr Patricia Crittenden.
- Local Needs Analysis Report, including evaluation of Ante-Natal Input.
- Consultation to health service professionals on "Promoting Children's First Relationships"

Challenges in Setting Up

Prevention and early intervention work is frequently sacrificed for crisis interventions and a variety of Resource constraints present significant challenges.

(1) The designation of allocated time for developing new services according to local need and informed by best practice within the research literature, whilst maintaining existing under-resourced services. Within our own service, our current duties include researching and developing services to respond to community need, allowing us some flexibility to pursue this area of work.

(2) Funding and opportunity for ongoing training and supervision to develop staff skills and expertise to work with infants psychologically, is still needed.

(3) Funding is required for additional public health nursing posts to carry their case-loads and allow them more time to meet with mothers and infants in their care and engage in some meaningful intervention work to prevent future difficulties.

(4) Addressing the lack of knowledge within services, managers and professionals, regarding the critical importance of early relationships for children, means engaging in a process that will inform and bring awareness at all levels required to pursue this work.

18 months on, we are just emerging from our own infancy, though our experience to date has been overwhelmingly positive, with professionals and families enthusiastically supporting a continued emphasis and need for this work.

Niamh Clarke & Sheena Burke, Senior Psychologists, Ireland.

Teaching assessment, diagnostic and treatment procedures from the DMM perspective

Bente Nilsen, Clinical child psychologist, Infant and toddler unit, Baerum BUP, Norway.

I have been working with a single mother and her two sons for a long time. When she asked me to help her to understand her 5-year-old son better and also to address her concern that her own anxiety was affecting her relationship with him, I suggested doing the Strange Situation. Doing the procedure created the opportunity for her to observe his mastery of the challenge. It touched her to listen to his fears as he spoke to the stranger (after first separation) and to himself when he was alone. As we closed the procedure, the mother grabbed my hands and said, "This was very important to us. We have to look at it again!" She said this with real hope in her voice.

This case was presented as part of a three-day clinical seminar on assessment, diagnostic classification and treatment in pregnancy and in families with infants and toddlers at risk, sponsored by the Norwegian Psychology Association (NPF). Mette Sund Sjovold, from Aline Infant Clinic, and I worked with 15 psychotherapists, psychologists working with severe developmental disorders, and forensic therapists from child care units and preventive health units. Our goal was to present the DMM perspective on interaction, the attachment relationship and treatment. Some of the participants had recently attended other seminars focusing on "disorganization", and this opened fruitful discussions on one major issue that differentiates the DMM from other theories, namely what theory underpins hope. The concept of disorganization, as used in Norway, bears the message of hopelessness.

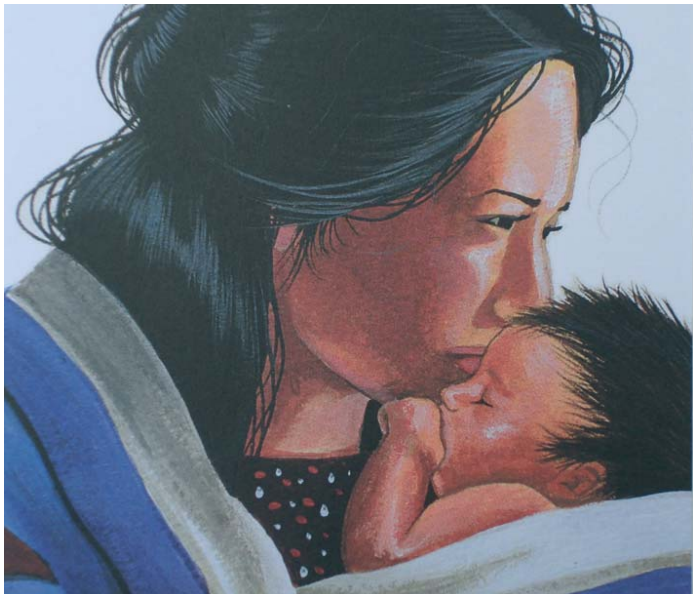
We issued only one article to the participants, and as one psychologist proclaimed, "I received only one article. And it turned out to be one that grasped everything one could dream of reading!" That article was Pat Crittenden's "Molding clay: The process of constructing the self and its relations to psychotherapy".

In the seminar, we explored the analysis of mother-infant interaction, using questions from the CARE-Index manual as ways to open what Daniel Stern calls "now" moments in therapy. We also looked at how viewing strange situations with parents can guide mutual exploration of the parent-child attachment relationship. We closed the topic of treatment with exploring why parents do as they do through understanding their psychological organization. The seminar really focused on hope, as do Pat's words from "Molding clay":

"[Psychotherapists] should be comfortable with self-awareness, with the uncertainty of change, and with the process of integration of discrepant representations of self. Without these competencies, they cannot guide another person, particularly a suffering person who has been exposed to threat in intimate relationships, through the challenging process of self revelation and change. […] The self is never static, never complete. Its emergent qualities create hope." (p.11)* Also on www.iasa-dmm.org

*Crittenden, P.M. (2000). "Moldear la arcilla. El proceso de construción del self y su relación con la psicoterapia", Revista de Psicoterapia, 41, 67-82. Dedicated to Vittorio Guidano.

Promoting parent-child attachment at a population level as a public health imperative: Lessons learned from Triple P in Manitoba



In March of 2005, the Government of Manitoba's Healthy Child Committee of Cabinet (HCCC) announced their support for the province-wide implementation of the Triple P - Positive Parenting Program as a population-level public health initiative to provide parents with evidence-based parenting information and resources. HCCC is the only standing Cabinet committee in Canada dedicated to young people's well-being. Manitoba province has a diverse multicultural population of over 1 million. From urban areas to the remote north, per capita it has the largest Aboriginal population in Canada, creating a unique cultural context for large-scale program delivery. The huge mismatch between family numbers and available specialist mental health services, indicated that a public health approach to strengthening parent-child relationships at a population level was imperative.

Triple P is a parenting system that focuses on helping parents to develop and maintain positive relationships with their children and has been shown to reduce prevalence of child maltreatment and serious behavioural and emotional problems in children. Created by Professor Matt Sanders at the University of Queensland in Australia, the program is founded on a remarkably strong international evidence base of efficacy, effectiveness, and research, with over 30 randomized controlled trials published over the last 25 years. Currently, it is being implemented in an increasing number of countries worldwide.

This population-level public health initiative is unique to government in that it is being implemented through a wide variety of practitioners across sectors, by utilizing the existing workforce to reach families in need. Since 2005, the Healthy Child Manitoba Office (HCMO) has been engaging community agencies, regional health authorities, child care providers, family resource centres, school divisions, mental health professionals, and other organizations to partner on this new approach to supporting parents and parent-child attachment across Manitoba. Using criteria that focus both on community need and community capacity, the Triple P practitioner training is being rolled out across the province, in phases that include rural, northern and urban regions.

HCMO has been gratified by the enthusiastic response from communities, agencies, and practitioners to the implementation of Triple P within our province. To date (April 2008), approximately 650 practitioners representing 150 community agencies and organizations have successfully completed Triple P training and accreditation. We are now rolling out program delivery, with an official publicity launch in September, 2008. We are collecting feedback from practitioners to gain lessons for continuing implementation, and for others planning to deliver programs to support families in building healthy relationships with their children.

Lesson One: Prepare

The investment of resources in planning in advance of any public health initiative is key. In particular, the wise investment of time and energy to outreach and community engagement at the outset. Existing systems, organizations, and communities have varying levels of enthusiasm, readiness, and resources to implement any new initiative, and collaborating with 'champions' who are most ready and able to move ahead has been a positive step in successful implementation and reaching the families we aim to support. Prioritising these relationships is the foundation for long-term sustainability in a large-scale program.

Lesson Two: Support

Practitioners appreciate engaging in ongoing dialogue regarding training and incorporation of the program into their service delivery models. Practitioner and manager support groups for Triple P have encouraged practitioners and agencies to follow through and incorporate the program within their existing service delivery model, thereby increasing their population reach.

Lesson Three: Learn

When implementing such a program, it is vital to learn more about and come to know your practitioners, their communities, and the individuals they serve. HCMO has conducted numerous consultation days around the acceptability and applicability of Triple P in Aboriginal communities and agencies. We are currently working on an Aboriginal parenting project to learn more about the strengths and practices of our parents in diverse communities across the province. A dedicated training session and consultation day are also held for agencies, families and practitioners working with families who have newly immigrated to Manitoba to better understand their needs. This shared understanding is imperative in collaborating with practitioners around fitting the program into unique and diverse cultures and communities.

Lesson Four: Communicate

To maximize the population reach of an intervention, it is important to consider appropriate ways to demonstrate its benefits to potential partners in their work as practitioners and organizations with their clients. It is also key, to not only acknowledge the fine work that organizations are already doing with the families they serve, but also to highlight the role they play in the bigger picture of improving parent-child relationships at a population level. Collaboration is key to encouraging creativity in fitting new interventions with existing work. It is important when bringing on new practitioners and organizations to clarify the commitments that will be expected of them in terms of both completing the training process, and with delivering the program as part of routine practice across sectors and service delivery systems.

Preparation, support, learning and communication help establish strong collaborative relationships with and between practitioners, organizations, communities, and the public, and are prerequisites to achieving positive outcomes for the families we seek to support.

Jennifer Volk (1 & 4), **Steve Feldgaier** (1 & 2), **Rob Santos** (1 & 3), **Kelly Penner Hutton** (1 & 4), **Deb Campbell** (1) and **Jan Sanderson** (1).
(1) Healthy Child Manitoba Office, Healthy Child Committee of Cabinet, Government of Manitoba; (2) Department of Clinical Health Psychology, Faculty of Medicine, University of Manitoba; (3) Department of Community Health Sciences, Faculty of Medicine, University of Manitoba; (4) Department of Psychology, Faculty of Graduate Studies, University of Manitoba.

Families at risk, from pregnancy to pre-school years: creating a clinical approach from a DMM perspective.

Bente Nilsen, Anne Vaglum and Agnes Aarre, Clinical Child Psychologists, Baerum Child and Adolescent Outpatient Clinic.

In May 2007, we created the Unit for Infants and Toddlers in our outpatient clinic to serve families who are at risk for psychopathology from pregnancy up to 5 years. We aimed to serve families where there were risks such as:

- Parental symptoms such as depression, anxiety or personality disorders.
- Infants who had been born prematurely, or who had developmental disorders or delay, medical conditions, behavioural problems or regulatory disorders.
- Relationship problems between parents and infants, such as discord in interactions, abuse or neglect.

In 6 months, we worked with 44 families (2 pregnancies, 11 infants under 12 months, 9 infants 1-2 years, 7 toddlers 2-3 years, 3 toddlers 3-4 years and 15 in the preschool range - above 4 years). Referral issues included:

(1) Regulatory, tied to feeding, sleeping, affect, behaviour and interaction.

(2) Behavioural issues such as head banging, eating disorders and aggressiveness.

(3) Delayed psychomotor development.

(4) Relationship discord.

(5) Stressors in the family (somatic illness, premature birth, death or trauma, psychiatric illness, parental discord).

We collaborate with other agencies including education, child care, public health services, child mental health services, paediatrics, day care, general practitioners, and adult out-patient psychiatry.

Illustration by Anna Fiske

Our theoretical and methodological orientation is within the DMM, using the CARE-Index, PAA and AAI. Along with that, we have theoretical and therapeutic orientations towards family systems theory, the psycho-educational approach, developmental psychology, affect theory and interactional therapy based on video feedback (e.g. Marte Meo).

Our team has a variety of training in DMM methodology, but as we discussed our professional approach to the clinical challenges that were ahead of us, we all felt that we needed to have methods that could meet the needs of assessment as well as treatment. We were concerned that our focus should be treatment, and not solely assessment, so we could meet - and potentially shape - the criteria for providing evidence-based treatments.

Creating such a unit is a work in progress, and we feel excited about dealing with issues that emerge early in human development. We have begun to see that we can help family members to improve their communication and to share moments of experience. These might seem unattainable goals, but in looking at videotaped interactions between parents and infants, with a valid method for understanding the functional aspects of interactions and the attachment relationship, we see the emerging results and the solid reasons for keeping these kinds of goals alive.

In preparing for this treatment unit, our questions are numerous. How can we create treatment interventions based on interaction analysis (CARE-Index), and assessment of attachment (SSP, AAI)? How can these methods supply themes and issues for treatment that are valuable for both infants and their parents? How can individuals create meaning, reflect on their past and present experiences and at the same time keep their interaction and attachment relationship with their infant and toddler in focus? How can we create a treatment intervention that avoids teaching parents to “do the right thing” from the perspective of others, as we represent authority ourselves? How do we avoid just stimulating the accumulation of unresponsive, yet active, parental interaction behaviour? How can these methods provide a better tool for parents to observe their infant’s initiative and signals, their desire for comfort and expression of positive and negative affect?

We cannot yet answer all of these questions, but nevertheless we proudly ask them! Our experience in working with families in the field of child and adolescent psychiatry and preventive work makes these questions very important. As we meet families with prior experience of treatment, we are surprised by how easily families assimilate professional ideas about their lives, their children and how to behave, and yet they often seem unable to describe what they observe about their own children, and how they understand their child’s desires and needs.

Conversion disorders - phylogenetic roots in innate animal behaviour?

Review by Airi Hautamäki, Professor, Swedish School of Social Science, University of Helsinki.

The elusive conversion disorders have enticed the attention of doctors and therapists since Jean-Martin Charcot, Pierre Janet and Sigmund Freud. In her article, **'The developmental origins of conversion disorders' (Clinical Child Psychology and Psychiatry, 2007, 12, 487-509), Kasia Kozlowska** presents a novel conceptualization of conversion disorders in terms of their evolutionary origins. She draws a distinction between two kinds of conversion disorders. Their roots are in the two innate animal defensive behaviours in response to danger, i.e., the 'freeze' and 'appeasement' responses. Defensive behaviours in humans have evolved gradually, both in the context of predatory threat and threat from other human beings, particularly those who are supposed to take care of the child. Even in post-industrial, Western societies, child abuse and neglect are prevalent.

Kozlowska stresses that observations of children in stress-eliciting procedures (for example, the SSP and PAA) indicate that freeze behaviours are incorporated in the compulsive Type A strategies. Type A+ self-protective strategies are seen in endangered children presenting conversion symptoms in the context of inhibition of affect. With the help of illustrative case presentations, Kozlowska analyses the conversion reactions in terms of freeze behaviour. She also presents a case in which a Type A+ child is unable to maintain his inhibition, as stress rises. The negative affect intruding is seen as intense negative distress, e.g., the child falling without self-protective reflexes.

C+ strategies are connected to conversion symptoms in the context of alternated and exaggerated displays of aggressive-threatening or feigned affect. Thus, the attachment strategies underlying the two types of conversion symptoms have distinct phylogenetic roots in self-protective responses to external threats. The children manifesting the different conversion symptoms are characterized by distinct developmental pathways. Conversion symptoms tied to compulsive Type A are often manifested as discrete neurological symptoms, tied to inhibition of negative affect. The second developmental pathway originating from Type C appeasement behaviours is observed in toddlers with conversion disorder who strongly show pain behaviours, conspicuous impairments in neurological function, or body enactments of negative affect.

Kozlowska concludes that the conversion disorder bound to a Type C+ attachment strategy represents implicit deception. It is automatically triggered and based on the preconscious memory systems, i.e. imaged and procedural memory. Implicit deception should be distinguished from explicit deception, e.g. feigning neurological symptoms bound to the Type 7-8 attachment strategies. Type 7-8 emerges in adolescence, and is more prevalent in anti-social populations.

The author reformulates the concept of 'disorganization'. According to Main & Solomon (1990) and Solomon and George (1999), children would become disorganized in the face of danger, and the disorganization of the child's attachment strategy would even increase with age. Kozlowska, using the DMM, takes an evolutionary perspective. In order to survive and cope with threat, endangered children must organize in more complex ways than would have been necessary in caregiving contexts that provide protection. Kozlowska's reformulation of disorganization agrees with Bowlby's (1969/1982) universality thesis of attachment; a propensity of the infants to become attached regardless of their cultural niche. But these globally adaptive, behavioural propensities are realized in specific ways, as a function of the cultural niche in which the children have to survive.

The author proposes that the so called "disorganized" behaviours are either based on freeze behaviours, e.g. extreme stillness, stiffness of the body or a limb, interrupted and jerky movements, anomalous postures; or, at the other end of the continuum, they reflect the use of exaggerated appeasement behaviours, e.g. intense displays of extreme fear or feigned helplessness. Thus, the supposedly disorganized behaviors are not disorganized. Instead, they reflect the incorporation of innate defense behaviours into more complex patterns of attachment. In terms of the DMM (Crittenden,2004,2006), and in contrast to Solomon & George (1999), and Hesse & Main (2006), the author concludes that, as a child grows into adulthood, and with the help neurological maturation, there is increased complexity in the self-protective attachment strategies in the face of danger.

Clinically, the distinction between two qualitatively different conversion disorders, as well as between implicit and explicit deception, is helpful in formulating hypotheses in family assessment and planning the treatment. Conversion disorders in the context of exaggerated display of affect need intervention stressing structure and predictability, whereas the conversion symptoms in the context of inhibition of affect need intervention in which the children are assisted in deepening their awareness of body states and communicating negative feelings.

The author draws the proposed model from the DMM and her clinical experience with children and adolescents. She stresses that the new distinctions drawn between different developmental origins of conversion disorders require further empirical testing with larger and more diverse populations. The DMM will allow a more clear-cut useful differentiation between patients who suffer from unexplained neurological symptoms, and also between those who use implicit versus explicit deception.

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Use of the DMM in early intervention with infants and families in Portugal

In an effort to provide support for children with developmental problems and their families, a small group of professionals created a private centre in Lisbon: the Gabinete de Apoio ao Desenvolvimento Infantil e à Familia (GADIF). GADIF has a home-based program with different services, such as developmental psychology, family support, physical therapy or speech/language therapy. This program promotes the healthy development of children under six years old by empowering families and reinforcing positive caregiving. Moreover, the program seeks to attend carefully to attachment issues. In addition to its clinical work, GADIF has several ongoing research projects.

Becoming familiar with the Dynamic-Maturational Model - DMM

In 2002, the GADIF Project coordinator, Marina Fuertes, and later the rest of the team, became familiar with the DMM, starting with an overview course about Attachment and Psychopathology. This theoretical framework was used as the basis for attachment research (Fuertes, Lopes-dos-Santos, Beeghly & Tronick, 2006) and informed GADIF practices.

Using DMM to help the 'cat boy'

When the pre-school teacher and parents raised concerns about this 3 year old boy, we arranged the first family meeting, and just listened! Tomas presented significant language and motor delay, and was described as not caring about being alone, rarely seeking his parents and "as independent as a cat". His parents noted his clumsiness and frequent falls. His family members were urban, well-educated and desperate for answers.

Further evaluation included The Griffiths Mental Development Scales, to assess cognitive and motor development. Naturalistic observations at school showed Tomas had a lack of intentional communication (especially with peers) and he used destructive behaviour as a principle strategy to interact. Frequently, he wandered around the room with little or no investment in activities, toys or people. At home, his parents found it very hard to control his erratic behaviour, which often put him at risk, and he rarely looked for his parents as a social reference or to find protection.

Tomas' lack of social reciprocity was very stressful for his parents. The Pre-school Assessment of Attachment (PAA-DMM) confirmed a failure in the activation of an attachment pattern. Tomas "has not organized his affective behavior around an attachment figure who is perceived as serving a protective function" (Crittenden, 2000). On the contrary, Tomas showed no reaction to his mother's departure, and in the reunion episodes he didn't seek proximity with her and showed no struggle and no preference for mother instead of the stranger. In turn, his mother found it difficult to help Tomas get closer and to use her support as a secure base.

Tomas' paediatrician and pre-school teacher assisted in the evaluation process and this phase was completed with a final report analyzed and, crucially, discussed between team members and family. Clearly, Tomas' autistic spectrum traits were associated with a significant developmental and attachment disorder.

The personal impact of the diagnosis was different for both parents, and they had differing feelings of confusion and worry. Tomas' mother had spent days (and nights) seeking answers for her child's condition, whilst his father hoped Tomas' problem would resolve itself. As the DMM recommends, GADIF closely collaborated with the family, focusing on child behaviour and family support. Promoting attachment is the biggest challenge, and the DMM gave us confidence to plan Tomas' socio-emotional interventions. During the sessions, we invested heavily in work embedded in the family dynamics using videotapes, home observations, toy play, book reading, support given for the routines, and emotional support. We aimed to promote parental sensitivity and availability for

Tomas as well as Tomas' involvement. Initially, his parent's attention and energy was focused mainly on promoting Tomas' acquisition of new skills.

Home visits supported the parents' new perspectives by finding enjoyable closer interactions and organizing time for routines in relationships, such as baths together, play and story time. Sensitive eye contact was also encouraged. Consequently, Tomas and his parents learned to be closer, spontaneous and more playful.

Now, at 4 years old, Tomas tries to please his mother with his drawings as well as inviting her attention with tantrums and struggles, and his father notices Tomas' new protests when he pretends to leave him. Tomas' increasing enjoyment of playing and talking with his mother is now self reinforcing, and he has started exploring behaviors with different functions. At the same time, learning about attachment helped his parents to understand their cognitive role in relation to his behavior. Recently, Tomas asked his mother, "What are you doing mum? Are you coming to take care of me or not?"

Without prescriptions and with a critical and enquiring spirit, the team remains dedicated to this case. The primary results of the Integrative Intervention Program are endorsed by the comments of Tomas' mother:

"These activities performed in our own home enable us [parents] to use and practice important skills with our child, with appropriate tools. We would probably have thought that these strategies were something only professionals could do. We can see the benefits for Tomas' growth and development. Our child is a very good example of this! There is a strong psychological effect and when you start doing that, it really makes our family feel a whole lot better about ourselves".

What the DMM offers that's different from other attachment approaches

The link between maternal sensitivity and attachment status founded by Ainsworth and colleagues (1978) inspired a range of interventions in parent-child relationships. To enhance such relationships, attachment-based programs focus on maternal behavior, maternal representations, child behavior and on other caregiving contexts. The DMM model, as a framework for practice, gives a crucial additional contribution to more traditional approaches by:

- Conceptualizing attachment status as a dynamic and dyadic process, not just existing in the child. It is the dyad that finds the conditions to establishing (or not) attachment security, and so the intervention process needs to be planned for both people in the dyad.
- Seeing attachment strategies as self-protective strategies. Each individual's attachment style is their best protective strategy to cope with their caregivers and environment, and so care is needed when attempting to change or remove their life-jacket!

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- Emphasizing the need to understand the context where the child learned to organize their behavior self-protectively. For example, a child's tantrum can help a withdrawn mother to return to an interaction, and avoidant behavior can be the best way to deal with an intrusive caregiver. Contextualizing the intervention and adapting our work in a multimodal approach takes into account different levels of influence on the child's social and individual development.

- Emphasising processes and the dyadic and family functioning, rather than dichotomous labels such as 'secure versus insecure'.

It is hopeful to recognize that the organization of the attachment processes is not rigid, and we know that once a new and more desirable balance is found, a step backward is unlikely. The DMM model gives professionals a solid grounding, and also increased cause for optimism in their work.

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Up-coming training courses

Attachment & Psychopathology

Dates: 5 days, 29th September - 3rd October 2008

Lecturer: Patricia M. Crittenden at Bertinoro

Content: This is a developmental course from infancy to adulthood on development of risk for psychopathology and treatment. It introduces basic ideas from the Dynamic-Maturational Model of attachment and adaptation. It is prerequisite for all DMM assessment courses except the CARE-Index (but is suggested for the CARE-Index). For more information, see www.patcrittenden.com

Cost: $600 IASA members / $800 for non-members

Contact for information and registration: Sabrina Bowen, jslnbo@bellsouth.net

CARE-Index

Dates: 6 days, 29th September - 4th October 2008

Trainers: Bente Nilsen & Steve Farnfield at Bertinoro

Content: The CARE-Index is a video-based assessment of risk in adult-infant dyads. It can be used for screening, treatment, and intervention (i.e., video-feedback) in individual or group settings. Participants will submit videos from their own work and complete a reliability test after the course in order to receive certificates. For more information, see www.patcrittenden.com

Cost: $800 IASA members / $1000 for non-members

Contact for information and registration: Bente Nilsen, nilsen.bente@gmail.com

Adult Attachment Interview (DMM Method)

Dates: 18 days, 20th - 25th February; 18th - 23rd May; 19th - 24th September, 2009

Location: Reggio Emilia, Italy

Language: English

Lecturer: Patricia M. Crittenden

Prerequisite: Course participants must have completed 'Attachment & Psychopathology' before completing the course.

Content: This course teaches discourse analysis for the AAI, particularly clinical applications of the AAI. It uses DMM methods. There is coding work between the sessions, a requirement to submit 3 AAIs carried out by the course participant, and a reliability test following the course. This work must be completed to receive certificates for administering and coding AAIs. For more information, see www.patcrittenden.com

Cost: $3000, including reliability test

Contact for information and registration: Sabrina Bowen, jslnbo@bellsouth.net

Simon Wilkinson is presenting on **Attachment** in Brighton, UK on the 20th June 2008. Contact Simon on simon.wilkinson@tele2.no

The CARE Index top up course with **Steve Farnfield and Elaine Thomson** at Portsmouth, UK on 23rd-24th June still has a few places. Contact steve.farnfield@ntlworld.com