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DMM news

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The international association for the study of attachment

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Contents

Introduction

When 'seeking comfort' or expressing true negative feelings in childhood has to be severely limited in the face of the threat of abandonment or violence, then children adapt strategically in ways to please dangerous parents. If their strategy fails even briefly, their punishment can make dramatic news headlines.

In our 4th newsletter we focus on sex and violence. Our contributors reveal how hopeful treatments need empathy (not exoneration) and that empathy can emerge from understanding.

We also have a resumé of the treats at Bertinoro, Italy, October 5-7 and still have a few remaining places. Or if you would just like to be included as a founder member, go to **www.iasa-dmm.org**. This opportunity closes at the conference. We are also looking forward to welcoming several representatives of the International Attachment Network who will be attending in October following a constructive joint meeting in London with IASA board members this summer.

Thanks to the very generous efforts of **Emilia Sasson** and **Carmen Gloria Alarcon Mûsseler**, we now have a Spanish translation of our newsletter **'Noticias DMM'**. We are really pleased with this as IASA has an especially large readership in South America!

Our next newsletter (No 5 in October) will focus on trauma and victims of violence. Please contact Mike Blows if you wish to contribute.

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

Bertinoro Conference

The preparations for the 1st Biennial IASA Conference at Bertinoro are almost complete and the program becomes more varied and exciting each day. The four strands **(early intervention / prevention, forensics, challenging conditions, and research)** are all there, but in addition several new topics have evolved, each with several presenters.

One of the most exciting is a look at how **government policy** affects people and can be influenced. Mary Courchene will discuss the effects on Aboriginal families of the past Canadian policy of 're-educating' children, over a period of 5-6 generations, by removing them to residential homes. Augusto Zagmutt Cahbar (Chile) will discuss the effects on psychological functioning of political violence associated with dictatorships. Melanie Gill (UK) will discuss her efforts to make English social policy more family-friendly. Irmie Nickel and her colleagues will update us on how the DMM is affecting service delivery in Manitoba. Although each speaker will refer to his or her local experience, these issues affect many people in many countries, not only directly, but also through immigration.

Several of our speakers will explore the **genetics and neurobiology** of adaptive and maladaptive behavior, from Lane Strathearn's (USA and Australia) Plenary session to Rodrigo Paz's (Chile) discussion of epigenetics, Kim Barthel's (Canada) look at the neurology of attachment and Simon Wilkinson's (Norway) study of somatization. The theme of **somatization** will be picked up by Kasia Kozlowska (Australia) regarding conversion disorders with other speakers looking at eating and gastro-intestinal disorders (Rudi Dallos, UK) and skin disorders (Wolfgang Milch, Germany). A video presentation by Margaret McConnville & Patricia Druse (Ireland) on sensory processing and attachment will give a hands-on understanding of the concepts.

The Round-table on **Culture and Attachment** will not only consider cultural variation in patterns of attachment and the context-adaptation that this implies, but also it will consider how different cultures can live together. Differences in power and preferences for living in respectful separation versus various forms of integration will be considered. Minority issues and immigration will be represented in many ways by different speakers. Most speakers will have a broad-based experience in more than one culture.

Another cluster of talks and posters will focus on **out-of-home care**. Rifkat Muhamedrahimov (Russia) and Charles Messer and his colleagues (Canada) will report on their interventions with Russian children and Canadian adolescents living in institutions and Robert Lee (USA) will discuss ways to improve foster care.

Finally, there will be two large developmentally oriented clusters. Many posters and talks will address **early intervention and prevention**, led by P.O. Svanberg and Shirley Gracias, both from the UK, with Bente Nilsen (Norway) and her colleagues offering a video presentation. Another cluster will describe work with **school-aged children and adolescents**. Several case studies will highlight the clinical implications of theory for these difficult to treat stages of development.

We have a serious and challenging conference in a setting offering quiet vineyard walks, gorgeous sunrises over the sea and sunsets over rolling Italian hills. At days close, a walk into the village of Bertinoro will offer regional Italian cuisine and fabulous local wines.

Victoria's Legacy

Pat Crittenden

This issue of the *DMM News* focuses on violence and sex. It's an appropriate moment to remember Victoria Climbié and reflect on what can be learned from her suffering so that we prevent - and do not inadvertently create - suffering in other children. Unfortunately, in our new zeal to protect, we may sometimes do harm. (Crittenden, 2008).

Victoria Climbié was an eight year old girl from the Ivory Coast whose great-aunt offered to educate her in Europe. A year later, Victoria died in a British hospital of emaciation, physical neglect and organ failure, with 128 bruises and wounds on her body. Despite repeated hospital admissions in both France and England, and child protection concerns, including her great-aunt accusing her boyfriend of sexual and physical abuse; no one protected Victoria, and she died. The great-aunt and her boyfriend were convicted and imprisoned.

That is the beginning of the story. Just as worrying is the outcome of the investigation that followed. Victoria had been seen repeatedly by professionals and her injuries were noted in hospital records. Why didn't anyone suspect child abuse and neglect? Actually, they did, but each time that explanation was dismissed as unfounded. Several professionals recalled that Victoria claimed that she wasn't abused and instead was just clumsy, that she smiled brightly and said she was fine. In hospital, she was a 'ray of sunshine', and 'she twirled down the halls'. The professionals concluded that she was happy and not scared or abused.

Of course, the report documents many slips in how information was kept apart so that no professional had the whole story at once. My interest here is to make two different points.

The first is that professionals need to recognize **false positive affect**. Hospitalized children are not supposed to be happy, especially not when they are injured, ill, underfed and separated from their parents. Even without information from other hospitals and professionals, each clinician who saw Victoria looking cheerful should have noted the discrepancy between her situation and her demeanor. False positive affect signals the possibility of very serious danger; it may hide true negative affect (anger and fear and the desire to be comforted). To protect children adequately, professionals need to know this and **use the signal to initiate further inquiry**.

The second point is that, in trying to prevent others from suffering Victoria's fate, professionals are becoming far more vigilant - and harsh. Because it is difficult to differentiate children like Victoria from children suffering mild hitting, slapping, and bruising, minor abuse is sometimes treated as if it were life-threatening. When discovered, action, in the form of removal from their parents and placement in care, can be swift. Even uninjured siblings are sometimes removed. No one wants to risk overlooking a child like Victoria. But removing children for mild abuse causes more damage than working with the family. Separation is frightening and painful - for both parent and child. Moreover, once it occurs, no one, neither parent or child, can ever again fully believe that they are secure together. Foster parents too, can be dangerous, and children's emotions and behavior can deteriorate in care. **Like strong medical treatments, removing children from their parents can be dangerous and it should be done only when absolutely necessary.**

My point is that **both** under-identifying and over-identifying danger are dangerous to children and families. The lesson from Victoria Climbié is that we must recognize and respond to discrepancy, especially positive affect where sadness or fear would be appropriate. To avoid professionals harming children out of good intentions, we must balance seeing danger everywhere with over-looking danger because it appeared to be happiness, when happiness was unlikely. We must learn to read affect accurately and combine it with other information to make appropriately protective decisions.

Quotes from Laming, L. (2003, July). *The Victoria Climbié inquiry.* Paper presented to Parliament by the Secretary of State for Health and the Secretary of State for the Home Department by Command of Her Majesty. London: Crown Copyright.

Crittenden, P. M. (2008). Raising parents: Attachment, parenting, and child safety. Collumpton, UK: Willan Publishing.

UK Family Policy Takes Shape on DMM Lines

After writing 'The DMM goes to Parliament', the final report reflected DMM ideas in emphasizing the importance to healthy development and pro-social behavior of:

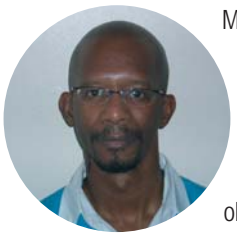
1. **Family relationships (both parental and spousal):** The report states: *We have stuck rigidly to attempts to change* behaviour*, but this is an outcome of an individual's state of emotional and social well-being. For genuine change to take place ... intervention must ... concentrate on improving parent-child relationships.* (2008, p.14)
2. **Family stability and coherence:** Several recommendations promote marriage through pre-marital counseling, conflict resolution services, and restructuring of taxation regulations and housing eligibility. The report specifically recommended 'fostering families' (2008, p. 23) rather than placing children in care (Crittenden & Farnfield, 2007) with the notion that the baby-boomer generation offers a huge resource of experienced parents who could function like parents to young and troubled families.
3. **Prevention through early intervention:** Eligibility for mental health services is contingent upon diagnosed problems - which defeats prevention. The report recommends changing eligibility to encourage assistance before problems develop. Early brain development is cited: *Children's brains adapt to the environment they live in ... An infant can grow up unable to handle stress well ... He or she can be persistently on the look out for threat, prone to anxiety, depression and anger, both in childhood and later life. Infants' core relational needs are secure attachment and attuned emotional responsiveness.* (2008, p. 15)
4. **Coordinated services:** *A key thread is a call for greater integration throughout service provision* (2008, p. 16, Crittenden, 1992). This includes both making access to services easier and also joint training for professionals from different disciplines and agencies. All DMM training is carried out this way - and we think it works to create shared goals and knowledge.

Breakthrough Britain: The Next Generation: A policy report from the Early Years Commission, Chaired by Dr Samantha Callan, September 2008.

Crittenden, P.M. (1992). The social ecology of treatment: Case study of a service system for maltreated children. American Journal of Orthopsychiatry, 62, 22-34.

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.

Sex and 'Staying Alive'

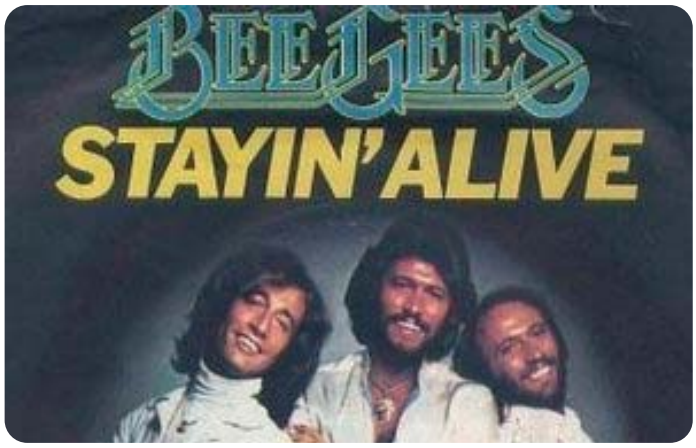


John Hoffman

My first exposure to the Developmental Maturational Model (DMM) of attachment and adaptation was in 2004, when I attended the Attachment and Psychopathology Seminar (A&P) in Reading, UK. I recall my enthusiasm for what appeared to be a coherent model that explained much of what I observed in practice. The DMM provided a new lens and language to conceptualise attachments in a way that I had not previously appreciated fully. I followed this up in April 2007, participating in the CARE-Index taught by Steve Farnfield in Portsmouth, UK. During the programme, Steve shared some evolving ideas and urged us to consider carefully the episodes when kissing appeared, analyse the context, and to get to the function! His counsel was met with both affirmative nods and some unease as the unspoken implications of what he said became apparent. Not only did sexual behaviour serve a specific function in the videos, by extension, it was likely that we have all used sex for a variety of reasons other than sexual ones. Obvious! But introspection is often uncomfortable.

I am a member of the National Organisation for the Treatment of Abusers (NOTA) so when I received notification for the conference, 'Sexual Harm and Attachment', in November 2007 by Dr. Patricia Crittenden, I thought that it was perhaps a sign that it was about time that I, too, found out what sex was all about.

The pre - course literature indicated that would I get not only to know about sex, but also a welcome recap of the DMM - with a specific emphasis on sexuality at each stage, followed by the application of these ideas to sexual offenders, their victims and treatment issues. The conference met my high expectations and I would like to flag three main points of the many that stood out.



First, 'Staying Alive' (announced by the Bee Gees) reaffirmed the aim, with safety and sex being the means by which we ensure life's goal. We explored the similarities between attachment and sexual behavioural systems and how, if one malfunctions, the other is sometimes substituted in an attempt to achieve the same end. This premise was an interesting one, especially when added to the further point of distinguishing between intention and outcome. The argument being that parents and adults sometimes use behaviours drawn from the sexual behavioural system with the intention of meeting children's attachment (survival) needs. For example, caressing the genitals could lower an anxious child's arousal, thereby increasing felt security. The obvious example of breast feeding was discussed, together with the taboo topic of how breast feeding could serve sexual functions for the mother.

Second, the notion of 'complicitous victimisation' called for a rethink of the simple 'perpetrator' and 'victim' dichotomy and an analysis of the victim's behaviour to see whether it may have increased the probability of victimisation. The point was to differentiate between multiple contributing factors and attribution of responsibility for the abuse. The notion of complicity was tied to older victims, especially repeat victims. For obvious reasons, this generated some very strong feelings. Some participants drew parallels with 'victim blaming' and thought that such an analysis of the victim's contribution might take insufficient account of the grooming process and serve the cognitive distortions often thought to be employed by the perpetrator. Crittenden tried to point out that the intention implied by the word 'grooming' might or might not be the abuser's actual intention and that the claim that the victim had signalled something might be descriptively accurately without the victim having intended to attract sexual attention. No doubt, the passion expressed in the discussion and over coffee, was fuelled, at least in part, by the media reports of, 'low conviction rates' for rape, and a tendency to hold women responsible for the sexual predation of some men.

The purpose of the analysis was to empower victims by encouraging them to consider whether their behaviour, e.g., coy behaviour, which had developed in response to certain contexts, was being generalised into other situations, and then misinterpreted and assigned a sexual meaning by the perpetrator. To bring this to the conscious attention of the victim could give them greater control, and thus minimise the risk of future harm. Crittenden pointed out that one of the greatest indicators of poor mental health is for a person to believe that there was nothing they could do to escape victimhood.

Finally, the notion of 'Evidence-Based Practice' has, quite rightly, gained prominence throughout the professions involved in care & control, therefore, Crittenden's citing of the work of Young, Kloskow, & Weishar (2003), Lilienfield (2007) and Creighton & Towl (2007) was challenging, and made us all sit up and reflect critically on our interventions, intentions and outcomes. Treatment was 65% effective - in the short term. No treatment was 50% effective, prompting the obvious question whether the net benefit of 15% was justified effort. Perhaps most compelling of all was the statistic that suggested that treatment was considered harmful in 15% of cases. Creighton & Towl (2007) reviewed 2039 studies, mostly CBT, looking at treatment for sexual offenders. Only 66 of the studies were considered methodologically sound, with only one study showing efficacious treatment - chemical castration. Possibly lack of alignment between the self protective strategies of the individual and the treatment offered could account for why our interventions, powerful as they are, seemed not to deliver the long-term outcomes we seek. The DMM is well placed to offer a new and perhaps better fit to the problem; it is developmentally sophisticated, suited to clinical populations, tied to adaptation under dangerous conditions and thus tied logically to treatment.

For me, as a practitioner and educator, I left with an odd mixture of feeling hopeful and yet uncertain. Hopeful, because it does seem clear that the DMM has a great deal to offer in the ways outlined above, but uncertainty because of the nature of the political discourse and public policy in Britain. We are increasingly obsessed with gimmicks and quick fixes. Complex solutions that cannot be reduced to sound bites are unlikely to be favoured over interventions that make grand, and seemingly, unsustainable claims. And, yes, I now know a little bit more about sex.

John Hoffman is a Guardian ad Litem in the UK.

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Adopting a Developmental Approach to the Treatment of Sexually Abusive Youths

Phil Rich

Treatment of juvenile sexual offenders is changing. Not only is treatment changing but, more importantly, our understanding of the experience of the children and adolescents who we work with is changing. We have begun to recognize that the development of sexually abusive behavior is not black-and-white and does not happen in a black-and-white environment. Neither can it be understood and treated in "one size fits all" models that focus upon psycho-education and cognitive-behavioral models of treatment.

We have, instead, seen an increasing awareness of the role and power of developmental processes and experiences in the lives and behaviors of sexually abusive youths. In turn, this has ushered in a significantly different way of conceptualizing the driving factors and forces that propel sexually abusive behavior, and human behavior in general. We are learning to embrace a far more sophisticated and holistic view that pays attention to these children and adolescents as 'whole' people in need of a multi-dimensional approach to treatment. This demands ideas and interventions that more clearly recognize the role and impact of social connection and early developmental experience. Most significantly, our change in treatment is driven by a change in how we understand the development of sexually troubled and abusive children and adolescents, particularly when compared to adult sexual offenders.

The importance of attachment processes in the behavior of adult sexual offenders was highlighted almost 20 years ago by William Marshall, and in the last five years we have seen increasing application of these ideas to young people. We now better understand the critical nature of recognizing, responding to and treating their early and ongoing social attachment and other social bonding experiences which led them to engage in sexually abusive behavior. There is a profound need to help re-shape these attachments and connections in the dynamic context of child and adolescent developmental maturation. In this light, we increasingly understand sexually abusive behavior as a crime reflecting attachment insecurity and a lack of social relatedness, rather than a problem primarily of sexual deviancy or delinquency.

These treatment ideas are still new. Nevertheless, the imperative that we recognize developmental experience and social attachment has taken hold. Our field more frequently acknowledges and pays attention to the complex elements that come together to form human psychology, including emotional and cognitive development, neurological maturation, genetic and biological predisposition, and the crucible of social experience in which they interact, with special emphasis on early and ongoing attachment and social bonding.

In our evaluation and treatment of sexually abusive youths, and in our conceptualization of these children, we see an increased focus on the social processes that promote the acquisition of essential social skills and a sense of social connectedness. We are understanding, and have concrete evidence for, the impact of the social environment on the neurological development of children, adolescents, and adults. The new technologies - with the current pioneering work of neuro-scientists like Martin Teicher, Michael DeBellis, Linda Spear, and Bruce Perry - point to the impact of early experience on the developing brain, including the experiences of uncertain, stressful, or physically and emotionally traumatic environments.

Gripped by new ideas and insights, and fueled by a new sensibility about the work we do, clinicians have come to both recognize the complex needs of the sexually abusive youths they treat and apply critical thinking to their work. Unidimensional and simplistic treatment models are being replaced, or at least augmented, by more clinically sophisticated and complete models that acknowledge the wholeness and complexity of clients and their needs. Clinicians are adopting a developmental approach, both to understanding the etiology of sexually abusive behavior and to providing multi-dimensional treatment in a relations-based treatment environment. This is well described by Longo and Prescott when they write, "Our new century finds growing support for (this) holistic/integrated model of treatment."

Phil Rich is Clinical Director of the Stetson School in Massachusetts, USA, and author of 'Attachment and Sexual Offending: Understanding and Applying Attachment Theory to the Treatment of Juvenile Sexual Offenders'.

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"A Search for the Human in Evil Deeds"

Peder Nørbech

Violence is a dreadfully exciting phenomenon. Many of us enjoy it on TV or in the movies, especially when the heroic figure brutalizes the bad guy. However the excitement is trans-formed when you are personally close to violence; then you are left with dread, anger and perhaps disgust. To give you a real sense of this, I would like to present a description of violence from one of the informants participating in my research on violent offenders (verbal extract from interview about violence):

"I say fine... you owe me money and it's about time you pay your debt... and he wasn't particularly interested in giving me the money, so then I look around the apartment and I find a battery drill... which is on a shelf... and then I say, "Okay now put your hand on the floor", and I put the drill on top... and when I start the drill, he pulls his hand back right and then screams that, "you can't do this", and such, and I say "give me the money you owe, then you won't have a hole in your hand", but he doesn't want to give up his money. Then I put the drill to his head and tell him that, "eh, it's your choice. Hand or head". And he puts his hand down again and I position myself with my foot on his hand so that most of his hand sticks out... and then I just drill through the hand.... aaaand theeen it went straight through the hand and down into the table... and while the drill is on and it has gone

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straight through, then he tries to pull back his hand right, so it... fucked up all the small bones... and everything, and then I tell him that now you have the choice... two hands... either you pay me the money or we continue... and then he agrees".

Even though we cannot know exactly what part of this is true, the telling of this event is horrific, sadistic, cruel and very violent. I presume that one could easily be filled with emotions like fear, anger, and disgust when reading it. What can we make of this man?

Instant answers like 'psychopath' and 'sadist' come to mind. Both are popular and scientific descriptions of people who 'in cold blood' commit horrific acts. However, most acts of violence are not like this. Instead, violence is a very heterogeneous and complex multi-causal phenomenon.

In the scientific literature, violence is usually described as affective or instrumental. Affective refers to violence triggered by strong emotional states of high arousal. Instrumental refers to consciously-intentional acts of violence, with lower arousal. In prison populations, only 1/3 of incarcerated violent offenders are found to be psychopathic, with the perpetrators being a heterogeneous population.

The term 'psychopath' in itself means nothing more than psychologically injured. Contemporary ideas of the concept describe psychopathy as a detached, aggressive form of personality disorder with a specific combination of personality traits and behavioural symptoms (Blackburn, 2007). According to the research community, psychopathic individuals are callous, grandiose, impulsive, and deceitful. They re-offend at significantly higher rates than other violent offenders and the prognosis for psychotherapeutic treatment is presumed to be practically zero or even negative. Recent research, however, shows that this claim lacks solid empirical evidence; hence the treatability of psychopathy is still an open empirical question (Salekin, 2002; D'Silva et al. 2004).

My research is focused on exploring underlying personality mechanisms and their development and association with the violent act itself. The etiology of psychopathy is still unclear (Blair, 2003), but is generally associated with an inborn fearless temperament (Lykken, 1957), low arousal (Hare, 1982), callous emotionality (Frick & White, 2008), and inborn detachment (Meloy, 1988), with a deterministic biological approach. I believe this perspective skews our perception and our treatment of these individuals.

Attachment theory, on the other hand, provides a developmental, experience-based perspective. Bowlby (1944) highlighted early separation as a precursor for the development of what he called the 'affectionless character', which closely resembles the modern picture of psychopathy. Bowlby's contribution on early separation is undoubtedly important, but we are now in a time where we understand how early endangerment shapes the regulation of affect, the inner representational world and identity-formation.

My interest in identity-formation stems from my clinical experience working with severely violent individuals in prison. From their AAI's I have learned that growing up in a world filled with horror and violence shapes self-perception. One of my informants chose 'Psycho' as his pseudonym for his AAI, saying: "My friends call me Psycho." Psycho's story was filled with early violence and neglect. Speaking about 'hate', he told this story:

"Those times he (angry voice)... my mother... that I there... actually in a way... the occasions where I watched him on his way too... five times... and if I hadn't arrived... where she would have been beaten... to death... (hm)... ...remember most of them... then I woke up... I don't remember what time it was... but it was in the middle of the night... late at night... when I say night... then it's... from 3 o'clock to 6 in the morning... by a hell of a noise (loud voice)... theeen... when I came down, down the stairs... that sight... wasn't good... the whole section that he'd bought was smashed... the sofa was chopped up in pieces with an axe... the telly was smashed... my mother laid in a pool of blood... and just in that moment... there... the last moment... he was about to drive a four kilogram candlestick into her head... and then she would have been stone dead... he stopped just when I... ...I was standing in the stairs there... and what is this?... (hmm)... ...I was 8 then".

If Psycho was the perpetrator in our opening scenario, would your perception of him change? Would you have more empathy for him?

But make no mistake, Psycho is a potentially very dangerous man. When his hostile inner world is activated, he will make you feel the horror that he has felt. He carries both victim and perpetrator inside, and we need to see both. Life in an institution might be our choice for him, but, taking into consideration his developmental background, we can understand that fear and violence are what he knows. Treatability is an empirical question, but being able to perceive him as human like ourselves, not a monster, is crucial to being able to work with him - and other very violent men. That doesn't mean that you don't get scared of him, you should, but he is still human and should be treated as such.

In dark times, theory helps me retain this perspective, and the DMM is such a theory because it both respects the developmental process that shaped each person and because it offers hope for change.

Peder Nørbech is a clinical psychologist and Ph.D student at University of Oslo and has worked at the Jessheim clinic in Ullersmo high security prison.

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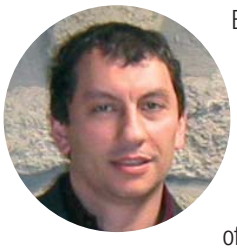
A Therapist's Perspective on Psychological Work Within Forensic Settings



Nicola Sahhar

Early in my clinical career on a forensic unit and before I trained as a psychoanalyst, my interest in psychodynamic thinking was greeted with suspicion by colleagues. It was easy to imagine that my patients, mostly labelled as 'schizophrenic,' displayed a similar attitude towards me, but in a more concrete way; some of them ignored me completely and didn't leave their rooms, whereas most of them just demanded that I meet their needs.

I remember vividly my first encounter with a more engaged patient. He was in his mid-fifties, had been addicted to alcohol for several decades, and displayed schizophrenic symptoms. Sitting opposite me with his ungroomed beard, he smiled at me with gleaming eyes, bent forward and described to me in vivid street language his first (non-violent) sexual contact, when 9 years old, with a girl his age. I immediately had an unwanted image of what happened in my head. Aware he was awaiting my reaction, I had no idea what to say or do.

I no longer recall what I said, but I remember that I was wondering about his motives. Why present this during our first therapeutic encounter? A few minutes later, he recounted how he was beaten by his father, and again I had trouble coping with an intense image of a boy, bloodied, being hit by a man in a barn. In spite of his shattering revelations, we came to like each other, despite this being unlikely at first.

A male colleague, who this man had greeted in the same way, was curious about my reaction. When I told him what happened, he was filled with indignation: "This is unacceptable behaviour! Disgusting! He shouldn't be allowed to speak like that." He described his rage about this patient, and refused to meet him anymore unless he apologized for his disrespectful revelations. Eventually, he prompted me to behave in the same "Professional"way.

I want to highlight some central features of interpersonal experience within forensic contexts:

1. Almost every encounter leads to self-reproach on the part of the professional.
2. Reproaches usually come unexpectedly and intensely.
3. You feel guilty, without being able to understand what happened.
4. Your 'guilt' is connected with almost every form of authentic self-expression, i.e. naively saying or doing what you think is not allowed. For example, on this unit there were limits on patients or staff talking about their experiences and resistance to thinking psychodynamically or in general psychological ways; that is, being interested in the relational meaning of strange, even violent behaviour.
5. Inhibition of self-expression is demanded, with an insistence to take other people's perspectives. Discrepancies between self and others are merely tolerated.
6. Although the surface of daily work appears calm, settled, even boring, you can bodily feel the high arousal being shut down.

What are the underlying motives and functions of these interpersonal dynamics?

A year later, when presenting the annual treatment plans to my boss, he conceded that he now understood the meaning of the patients' behaviour better, including their violent behaviour (without exonerating). However, he did not see this as a good thing: "But I don't want to understand the patients! This makes my work difficult. I can't work this way. Please, stop!"

A fundamental human need is to find oneself reflected and appreciated in the mind of another. This theoretical concept of 'mirroring,' is the starting point of an emerging sense of self. Disrupting this process can lead to severe psychological and interpersonal disturbance. With the help of a video-based assessment for infant-caregiver interactions, such as the CARE-Index (Crittenden, 1981,1988), we can directly observe how early dyadic developmental processes enable the development of a core-self. In some cases we see how far these early processes fail to assist the infant in his self-expression and development. Two aspects of this failure are described as:

- 'Unresponsiveness' - failure to respond to the needs of an infant; and
- 'Intrusiveness' - hostility (sometimes covert) towards the infant; punishing and rejecting the infant's needs.

In forensic contexts, I have observed both aspects. Some people lack sensitivity with a predominance of covert hostility. In extreme cases - in infant-caregiver interaction or within forensic settings - this is endangering, physically and psychologically. Forensic clients are usually physically endangering (mostly to others), and their histories, as in the above case, provide compelling examples of how dangerous life was when they were young and vulnerable. This doesn't exonerate them of their acts, but it enables us to share their perspective - and that is an essential starting point for change.

What of the psychological dangers? Reflecting on my first forensic experience; I was co-opted as a container of other people's self-experience. Disparate, barely tolerable experiences, connected with high levels of arousal, searched for validation in another human being.

To summarize: The intensity of experienced interpersonal trauma drives the fundamental need to find a counterpart who helps to regulate one's arousal by tolerating, mirroring and validating one's experience, and by doing so opens a space for therapeutic and psychological development. As in abusing families, in forensic settings we find a severe intolerance by professionals for the most needy clients. This can happen even among the most caring staff. Professionals and patients, especially in psychiatric and forensic settings, share the same fundamental need for self-validation.

At the same time, intolerance is challenged by the force of the client's demands to be included and considered in other people's minds. Perhaps sex and violence (or hints of) are (mis)used as a way of reaching out to find connections and possibly get help (Crittenden, 1997, 2008). If one is not able to find oneself in another's mind, at least one can enter the other person's body and leave proof of one's potency to affect others, even if it risks silencing them for ever.

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Resistance to Treatment in a Violent Offender: A Case Study

Raf is a single man in his thirties, currently serving an indeterminate sentence in the UK following conviction for homicide and sexual assault. He meets criteria for DSM-IV diagnosis of paranoid, antisocial, borderline, narcissistic and obsessive-compulsive personality disorders; as well as sado-masochism, and he has a high score on PCL-R (96th percentile for male prisoners). Since mid-2003, he has been undergoing treatment at a site specializing in the management of high risk offenders.

Raf grew up in the North of England. At home, he experienced physical abuse by his natural father until age 6, emotional abuse and neglect by his mother, then sexual abuse by his older brother. Nevertheless, he reported finding his stepfather caring and supportive (despite the latter's violence towards his mother). Due to truanting and disruptive behaviour together with unrecognised dyslexia, he was placed in a residential school, but returned home in school holidays.

After leaving school without qualifications, he was employed in catering, but increasingly became involved in heavy drinking, illicit drug use and criminality with convictions. His early heterosexual relationships were with older women and his sexual fantasies became increasingly violent. He had a period of outpatient psychological treatment following a prison sentence and he was due to begin further treatment when he committed the index offences: the murders of an elderly couple and two sexual assaults on young females.

During the early years of his sentence, concerns were expressed more than once by female staff, including two female psychologists, who felt seriously intimidated by him (one feared that he would take her hostage). The stages of the treatment programme in which Raf has been involved include weekly individual sessions and three weekly groups (cognitive-interpersonal, schema therapy and affect regulation). He was assigned to work with a female therapist and, from early on, repeatedly took control of sessions and raised his voice. The therapist recognised that this behaviour was a defence against intimacy and vulnerability and continued in her attempts to establish a therapeutic alliance for over three years. Apart from occasional sessions when he briefly revealed his underlying vulnerability, he became increasingly entrenched in therapeutic resistance, protecting himself by repeated verbal attacks of the therapist in individual sessions and in group sessions (particularly a group for which the therapist was a co-facilitator).

One aspect of his negative reaction to the therapist (and to other female professionals with whom he had had difficulties) was that she was quite close to his own age. His negativity may have developed partly as a defence against possible romantic/sexual attraction. Alternatively, it may have been based on his negative relationship with his mother who would have been about this age when he was a child. Support for this possibility came from his very different perception of older female professionals - he maintained a positive relationship (including acceptance of critical comments) with at least two older women and this may be linked with his more positive relationship with his grandmother as a child.

Due to the importance for risk reduction of his working through his negative relationship with the therapist, the treatment team resisted the idea of arranging a change of therapist. However it was agreed that he (and she) would have a break from sessions. During this break, he would have individual sessions with a male therapist with the aim of addressing the difficulties and preparing for a return to the original therapist. During this period, other members of his group have been working with him in group sessions, providing support, but also repeatedly challenging his negative and distorted view of his therapist and difficulties with her.

AAI interview was undertaken by a male interviewer about 2 years into treatment and before the difficulties with the therapist became so severe. The coding of his transcript gave results that are the most psychopathic in DMM terms of any prisoners interviewed as part of an AAI pilot study on the X Unit. The main coding was A7/C8, that is, delusional idealisation of his stepfather and triangulation with deceptively unpredictable danger regarding all relationships. There was also evidence of unresolved loss (the unexplained death of his sister when he was still a child) and multiple unresolved traumas from both physical and sexual abuse.

At the time of preparing this case study, Raf's future is uncertain. With the aim of reducing arousal, paranoid defensiveness and rumination, he has been started on Clozapine, an atypical antipsychotic medication usually used for refractory schizophrenia, but also beneficial for some types of personality disorder. At the same time, psychological treatment continues with the hope that this combined treatment will facilitate sufficient change to enable Raf to continue to progress in treatment. If this approach fails, it will be necessary for Raf to leave treatment and return to the mainstream prison population where his prospects of progressing towards eventual release will be very limited.

(Raf is the pseudonym chosen for the AAI interview and is the name used by some of his peers. Both peers and professionals were dismayed to learn the origins of the name - it is short for 'rough and ready.' This is what he was called by other children while he was in care due to his untidy appearance.)

Val Hawes, M.D. is a Consultant Forensic Psychiatrist in the UK.

Commentary from Pat Crittenden:

When three years of treatment has not produced change, it might be time to consider whether other approaches could be more effective. A basic concept in DMM-based treatment is to start where the individual is, not where he should be or needs to go. This idea is particularly important in criminal and child maltreatment cases where the gap between the individual's behaviour and acceptable behaviour is stark. Raf's AAI suggests that he might respect a fatherly figure, particularly one who did not offer more than he could deliver. Raf's behaviour suggests that he feels safer and more able to reveal himself with older women. Together, these suggest that he might be ready for supportive, parent-like therapeutic relationships.

Another DMM idea is that the strategies at the bottom of the model reflect 'comfort' disorders, i.e., conditions in which signals of comfort elicit fear and anger. Psychopathy (A7C7-8) is hypothesized to be the epitome of a comfort disorder. Raf's criminal behaviour suggests that he is not ready for relationships in which he must differentiate positive desires (for comfort or sex) from other arousing feelings (for example, anger and fear). This suggests the risks that might accompany being with a sexually desirable therapist.

In addition, Raf's criminal behaviour suggests that he attacks unknown people who might elicit desire for comfort or sexual desire. Therefore, older surrogate attachment figure therapists who used a cool form of structured and predictable empathy might be able to assist Raf to identify his feelings, tie them to specific events and images (so that they are elicited less frequently by non-relevant situations), and predict the relation between events, feelings and behaviour. Without awareness of this process of perception, arousal, and then action, Raf cannot be expected to regulate his feelings and behaviour well. These ideas run counter to the idea of affect regulation as being inhibition of negative affect (for a fuller explanation, see Crittenden, 2008). What I am suggesting is that affect awareness and recognition may be prerequisite to effective affect regulation. Negative feelings, in particular, should be viewed simply as information rather than something to be inhibited. As information, they need articulation and reflective consideration in a context that suspends the need to act. Once Raf recognizes his feelings, knows which conditions elicit them, and can discuss them in words, would it seem reasonable to consider regulating them, first in therapy, then in ordinary prison social situations, and, last of all, in emotionally charged situations (such as a young and attractive therapist.)

It should be stated clearly that these are untried, but testable, ideas drawn from theory.

Val's reply:

Yes, thank you Pat. We increasingly offer extensive affective awareness training at the outset. It would also help us to do the AAI early to find the best match of therapist.

New Directions for the Use of the *Adult Attachment Interview* with High Risk Offenders: A Pilot Study with Prisoners Meeting DSPD Criteria.

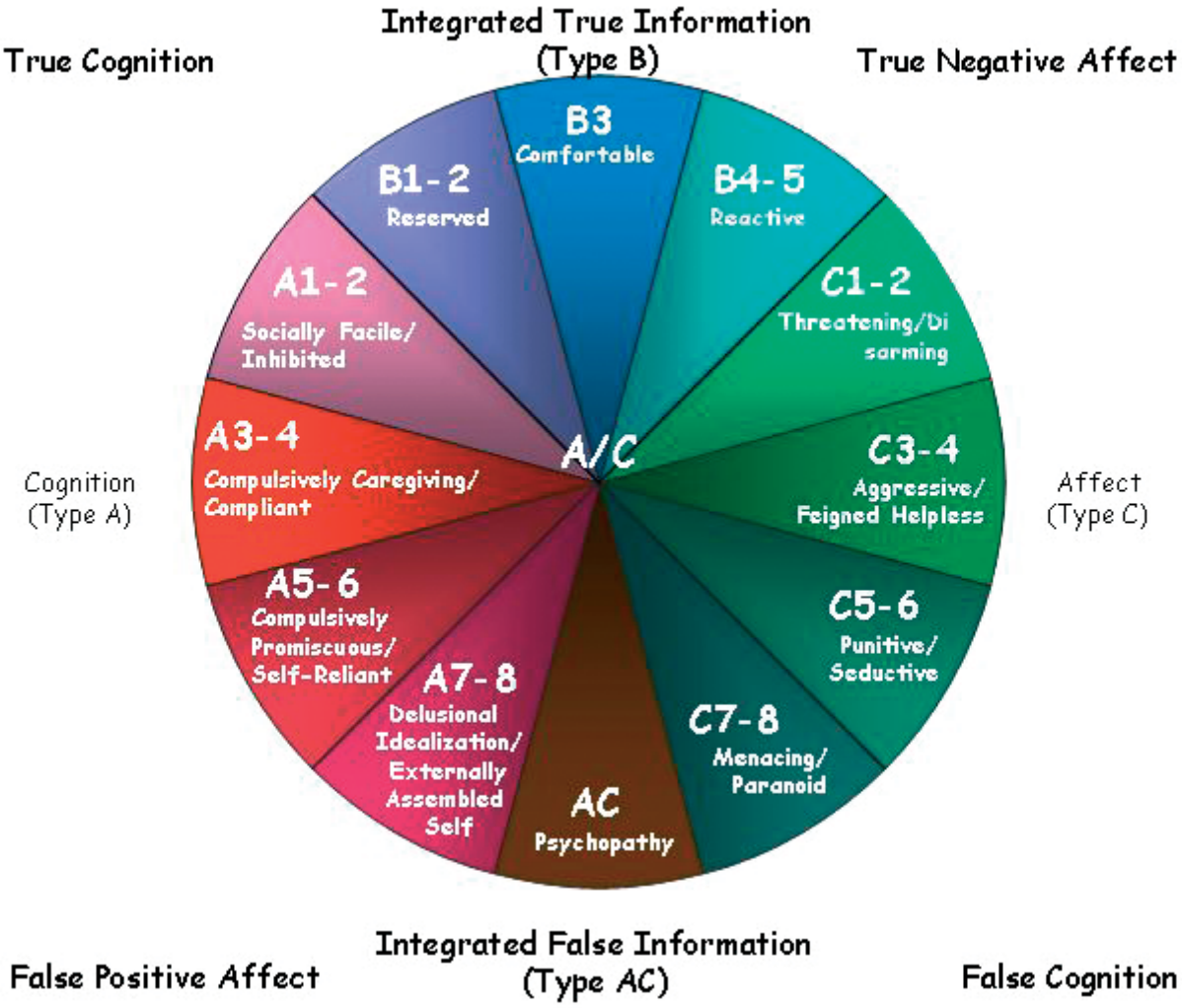
Introduction and background

The Adult Attachment Interview (George et al 1985) was developed from the earlier work of John Bowlby and Mary Ainsworth on attachment in young children. Over the past two decades it has been used extensively to assess the attachment patterns of adults in both normative and clinical samples using the ABCD classification developed by Main and Goldwyn (1994) and equivalent to the upper 5 sections of the circular diagram. As research has expanded to include a greater variety of non-normative samples, increasing difficulties have been noted in fitting all transcripts into this model. In an attempt to overcome this difficulty, Hesse (1996) described a 'cannot classify' group and in a Dutch study of personality disordered criminal offenders found that 53% of the transcripts in that sample fell into this group (van IJzendoorn et al, 1997). AAI research with a UK high-secure hospital population also raised both procedural and coding challenges (Turton et al, 2001) related to the extreme early experiences and psychological state of subjects, as well as the interview context in which subjects had given their life history many times.

The Dynamic Maturational Model (DMM), Crittenden (1997) provides a developmental approach to attachment theory and to the coding of AAI transcripts. This model recognises that individuals may have been exposed to ongoing and varying dysfunctional relationships and traumatising experiences throughout the developmental period. It emphasises that the attachment pattern is an expression of the psychological self-protective strategy developed by an individual in response to a variety of threats rather than as simply a measure of secure or insecure attachment. Increased variety and severity of threat leads to increasing distortion of cognitive and affective processing and this is evident in the AAI transcript. The DMM also provides an approach to understanding complex unresolved trauma and loss.

The DMM describes 10 basic strategies that may be shown in a circular diagram in which the upper 3 segments are all variants of Type B secure attachment patterns. Type A patterns involve an emphasis on cognitive processing with inhibition of affect and develop in response to relatively predictable parenting that includes actual threat or danger. More severe threat leads to patterns that may include compulsive self-reliance (A6) or delusional idealisation (A7). Type C patterns involve exaggerated affective display with ineffective cognition and develop in response to unpredictable threats and danger. In response to extreme threat, menacing (C7) and paranoid (C8) strategies may develop. Individuals who experience varying types of threat may also develop mixed strategies (AC) that in the most extreme form function in a stable manner in psychopathy, the mirror image of the truly secure individual (B3).

A Dynamic-Maturational Model of Patterns of Attachment in Adulthood



The Fens Unit at HMP Whitemoor is one of the high secure sites developed as part of the UK government strategy for the treatment and management of offenders meeting criteria for Dangerous and Severe Personality Disorder. The Unit (opened September 2000), situated on an adapted wing of the prison is staffed by a large multidisciplinary team of clinicians and operational staff. Over 50 prisoners are currently at various stages of the treatment programme based on a cognitive-interpersonal model.

Aim

The aim of the pilot study was to use the DMM approach to AAI interview with a small sample of prisoners in treatment on the Fens Unit, to assess its usefulness as an adjunct to regular assessment and formulation of treatment needs.

Method

The AAI interview was administered to a pilot group of 8 prisoners. The three interviewers are all senior clinicians on the Unit who had completed training in the DMM approach to AAI. The interviews were audio-recorded and the tapes fully transcribed. The anonymised transcripts were coded either at an advanced AAI Seminar or by the author of DMM.

Results

All 8 transcripts showed evidence of significant unresolved trauma and/or unresolved loss. The attachment patterns reflected self-protective strategies that included significant distortions of both cognition and affect.

Subj no	Index offence	Pers. Dis. diagnosis + Psychopathy Check List - Revised score	Summary of AAI findings
1	Homicide	Antisocial, borderline 30+	Utr(dx) A7/C5-6)
2	Homicide	Antisocial, narcissistic 30+	Utr (dx) A7
3	Homicide	Paranoid, antisocial 20+	Dp Utr(v) A3,6 C4-5 [ina]
4	Rape, attempted murder	Paranoid, antisocial borderline, narcissistic 30+	Dp Utr(dx) A7(8) [ina]
5	Homicide Sex. Assault	Antisocial, borderline, histrionic, narcissistic 30+	Ul(p),tr(dx) A7C8
6	Rape + homicide	Paranoid, antisocial borderline, avoidant 20+	Dp Ul(ds),tr(dpl,p) A?C3
7	Homicide	Antisocial, borderline 25+	Utr(dx) A?C5-6

AAI terminology: Utr/Ul = unresolved trauma/loss; dx = multiple moderators (disorganised); Dp = depression; v = vicarious; [ina] = intrusions of forbidden negative affect; p = preoccupied; ds = dismissed; dpl = displaced.

The AAI patterns were consistent with the known histories of the prisoners concerned but also yielded new information. They also provided an additional perspective and/or confirmation of clinical experience with implications for treatment:

- Delusional idealisation of a parent carries the potential for destabilisation as more realistic memories emerge in treatment.
- Intrusive negative affect evident during AAI interview is also likely to be repeatedly evident in treatment with possibility of planning and providing effective containment without rejection when this occurs.
- Where there is evidence of multiple and disorganised ways of coping with unresolved trauma, repeated cycles of working through the trauma can be expected.

Conclusions

- The DMM approach allows for the detailed classification of AAI transcripts of high-risk personality-disordered offenders. The AAI information, confirmed previously known facts and provided additional perspectives relevant to psychological treatment. Further work is needed to adapt this information for presentation to prisoner-subjects and to therapists not trained in DMM.
- Those prisoners whose self-protective strategies (as revealed by the AAI) include a strong cognitive element are unlikely to benefit from CBT programmes for risk reduction. They are more likely to benefit from treatment that emphasises the need for affective change and that which addresses past trauma.

Proposal for further research

Work is under way on the Fens Unit for a proposal to continue research using the AAI. This research will include the following elements:

1. AAI interview to be conducted with all consenting prisoners to develop a database of DMM-coded interviews for this high-end forensic population. Results will be compared with a database developing through similar research with high-risk offenders in Norway.
2. As AAI interviews will be conducted with individuals at different stages of treatment, results obtained at three stages of treatment will be compared.
3. After coding, a summary of findings will be provided to each prisoner and his individual therapist. Response to this feedback will be investigated by qualitative interviews (using a grounded theory approach) with both prisoners and therapists.

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