Assessing Attachment for Family and Children's Court Decision-Making:

A Protocol for Empirically-based Evidence Regarding Attachment

The IASA Committee on Family Attachment Court Reports

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Abstract

Attachment has long been considered relevant to care proceedings. Nevertheless, its usefulness, as compared for example to medical evidence, has been limited by the diverse ways in which it is assessed, the different training of experts, and the lack of verifiable evidence upon which many opinions are based. In the light of recent advances in theory and assessment, The International Association for the Study of Attachment (IASA) has developed a protocol for assessment and formulation of issues related to attachment. The purpose of the protocol is to act as a guide to good practice and to begin a process of improving the application of attachment to family court proceedings.

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The importance of attachment in family and children's court proceedings

Attachment addresses how individuals, from infancy to adulthood, protect themselves from threat. In particular, the assessment of attachment makes visible the mental processing and behaviour that has been learned by both adults and children in order to be safe and feel comfortable. Therefore attachment is of particular significance for making decisions about children involved in court proceedings as a result of maltreatment or parental conflict. By using direct observation, interpreted systematically, assessment of attachment can address both the immediate state of relationships and also the historical experiences that have shaped parents' and children's strategies for staying safe and eliciting care. From this, the likely effects of maintaining things as they are, or of possible interventions, can be estimated.

Early assessment of parent and child attachment relationships can (1) promote the selection of appropriate interventions, (2) avoid the inadvertent use of interventions that amplify family problems, (3) identify family members' resources and vulnerabilities (especially those that are not often or easily discerned through social work assessment or psychiatric diagnosis), (4) address issues of how family members function together (e.g., parent-child relationships, couple functioning, and family patterns), and (5) indicate which family members are central in changing family functioning. This information can potentially prevent escalation of problems. A secondary goal would be to lower the overall cost of delivering services by intervening early.

Nevertheless, when preventive or ameliorative efforts have failed, care proceedings may be initiated. Formal assessment of attachment by trained and authorized personnel is especially important in court reports because it permits scrutiny of the basis of the expert's recommendations. In the long term, feedback on outcomes would lead to application of what is learned to future cases.

Assessment of child and caregiver attachment relationships is an important component of a comprehensive clinical report in both care and family court matters. Other components include (1) family history and genogram; (2) chronological history of contact with social services, including descriptions of precipitating crises and the impact of previous interventions; (3) cognitive, language and physical development; (4) disabilities and chronic medical conditions; (5) adaptive, academic and employment history; (6) mental health and behavioural evaluations; (7) relationship history; and (8) forensic history. A formulation integrating all these data with attachment findings is essential to developing recommendations flowing from the formulation (see page 8 for alternate ways of reaching the formulation).

Limitations of current practice regarding attachment

There are three primary limitations to current family forensic practice regarding attachment: 1) defining attachment, 2) authorizing experts, and 3) provision of evidence that can be reviewed by other experts.

Attachment. Although 'attachment' is now a commonly used term, in reality there are many different meanings ascribed to the concept and courts are rarely told which meaning is being applied. This often leads to confusion in instructions from the court.

The most universal distinction is between secure and insecure attachment, with the latter usually used to imply dysfunction that requires intervention. Although almost everyone agrees that families coming to court attention are characterized by insecure attachment, the types of insecure attachment vary greatly from one model to another. Three are most common: a psychiatric diagnosis of reactive attachment disorder (American Psychiatric Association, 2000), disorganized attachment (drawn from Main's ABCD theory; Main &

Solomon, 1986; Main & Hesse, 1990), and an array of high numbered classifications in the Dynamic-Maturational Model of attachment and adaptation (DMM, Crittenden, 1985a, 1995, 2008; Crittenden & Landini, 2011).

This protocol is based on the use of the DMM and assessment tools developed within the model, although the questions raised here about the assessment of attachment are relevant to all models. There are several specific advantages to the DMM.

First, the DMM categories differentiate *among* children and adults with troubled patterns of attachment, whereas reactive attachment disorder and disorganized put highly heterogeneous cases together in one category. Second, the DMM categories are tied to both information processing and behaviour; the other two approaches assess behavioural aspects only. Third, the information processing underlying the DMM categories indicates that opposite neuropsychological processes may be used by individuals with different types of attachment (Strathearn, Fonagy, Amico & Montague, 2009). If this is accurate, then different interventions may be needed: inappropriate interventions may amplify psychological distortions and maladaptive behaviour. The DMM categories provide the needed specificity. Fourth, the DMM categories are developmentally attuned, with suitable and interrelated assessments across the lifespan.

Other features of the DMM are that it treats attachment as an interpersonal characteristic and sees adaptation as systemic, involving the fit among person, family, community, and support services. This broad focus facilitates finding solutions to problems: by addressing the family condition, children's needs, parents' abilities, or community's service structure. The aim is to increases the probability of finding novel solutions that can keep children in their parents' care whenever possible.

Defining expertise. Currently, there is no uniform means of assessing the expertise of those who report to the court on attachment. The practice in some countries of using an independent jointly instructed expert circumvents accusations of bias. However, without explicit specialist criteria, it can be difficult to establish expertise regarding attachment. In United Kingdom public law proceedings (i.e., care cases where the local authority is involved), the children's guardian is often influential in making recommendations regarding assessment of attachment. IASA is working toward developing guidelines to assist courts to identify competent attachment experts. Rather than rely on quantity of cases seen, with this protocol, IASA suggests monitoring current credentials of reliability, with priority given to professionals who can present such credentials. Below we detail what this means in terms of training and evidence of competence for those using the DMM.

Provision of empirical evidence. One of the most troubling aspects of current reports on attachment is the lack of evidence regarding how experts' conclusions were derived. Unlike medical evidence or photographic evidence of home conditions, conclusions regarding attachment often depend on descriptions of observed interactions which are difficult for others to review independently unless they are videotaped. Standardized assessments that both generate a permanent record that others can view and have peer reviewed published studies that address validity and reliability of the means for drawing conclusions from the observation would help to redress this. When such assessments are used, other qualified experts can evaluate the same evidence independently and render an informed opinion. This approach would also help to reduce multiple assessments of the same family by different professionals.

An approach to the admissibility of evidence to family courts. After the initial approval of this protocol, Ireland (2012) reported findings on expert witnesses to family courts in the UK. She found that 20% of experts were unqualified and only 20% of reports fully met proposed criteria for expert reports. The criteria proposed were based on *Daubert v Merrell Dow Pharmaceuticals* (1993) and modified to fit UK proceedings (Ireland, 2012):

I. With regard to facts and opinion:
   a. The report included the data from which the inferences were drawn;
   b. Each element of opinion could be linked back to a fact cited within the report;
   c. The author evaluated the quality of the evidence presented;
   d. Theory was used to support clinical opinion;
   e. Provisional opinion was included;
   f. A range of opinion was included;
   g. Allegations were not reported as fact.

II. Regarding method:
   a. The evidence met Daubert criteria as scientific evidence;
   b. They were relevant to the case;
   c. An outline was provided of the methods used to determine risk.

III. Regarding process:
   a. The extent to which emotive terms were avoided;
   b. The extent to which the report followed the structure dictated in the Civil Procedure Rules.

IV. Regarding qualification:
   a. The expert had active mental health practice (as opposed to full-time forensic expert practice);
   b. Based on the CV, the expert had the competence to complete the assessment and remain within their remit.

Retrospectively, we note that the IASA Family Court Protocol is consistent with these guidelines such that authorized coders using the specified assessment procedures should meet the criteria for admissible expert evidence.

Proposed Protocol of The International Association for the Study of Attachment

Based on the idea that assessment of attachment should move toward standardized procedures with authorized experts, IASA offers a protocol based on DMM theory, compatible life-span assessments, formal training, and authorizations of assessors by the organisation.

Expanded theory. The Dynamic-Maturational Model of attachment and adaptation (DMM, Crittenden, 1985a, 1995, 2008, Crittenden & Landini, 2011) offers several important features:

1. Definition: The DMM defines attachment in a way that is relevant to families in which children are endangered: Attachment refers to the self-protective and progeny-protective strategy used when there is actual or perceived danger or threat of danger (Crittenden & Ainsworth, 1989).
2. Maltreatment-related strategies: The DMM was developed initially in studies of maltreating families (Crittenden, 1984, 1998, 1999; Claussen & Crittenden, 1991; Crittenden & Claussen, 1993; Crittenden, Claussen, & Landini, 2001; Crittenden & Craig, 1990). The DMM strategies shown by many maltreated children and maltreating parents include: (1) compulsive caregiving of neglectful/depressed parents (Bowlby, 1980; Crittenden, 1992), (2) compulsive compliance to aggressive/threatening parents (Crittenden & DiLalla, 1988), (3) compulsive promiscuity and self-reliance in response to abandoning parents (Bowlby, 1980; Crittenden, 1995; Crittenden & Landini, 2011), (4) punitive/seductive behavior of older children and parents (Crittenden, 2008; Crittenden & Landini, 2011), and (5) delusional idealization of dangerous people (Crittenden, 2008; Kuleshnyk, 1984). See figure 1.
3. Information processing: Each of the behavioural strategies is tied to mental processes that describe how the mind misconstrues situations so as to endanger children (see figure 1). Although theory, as always, runs ahead of data, the early empirical results,

using fMRI data to validate attachment strategies (Strathearn, et al., 2009) are encouraging.

4. Strengths approach to children: The DMM approach to children's attachment emphasizes the adaptive function of children's behaviour in increasing their safety in dangerous contexts. That is, rather than focusing on what children lack (a deficit approach) or their troublesome behaviours (a symptom-based approach), the DMM addresses the protective function of the organization of children's behaviour. For example, acting out can be protective – when parents are preoccupied with other things and the child needs attention to be safe. Similarly, hypervigilance and inattention to school work can be an adaptive strategy when the child has learned that danger can pop up anywhere, anytime. Crucial to this functional perspective is placing children's behaviour in its interpersonal context. Unfortunately, when the behaviour becomes habitual, it affects perception and attribution of meaning by both parents and professionals. These psychological processes can also affect a child's behaviour in non-threatening contexts, thus rendering formerly adaptive processes maladaptive. Further, children who need these extreme self-protective strategies are rarely happy; the strategies often increase their safety with their parents, but not their comfort. One advantage of the DMM conceptualization is that it directs attention to children's competence and motivation to protect themselves. In addition, it gives meaning to behavior that is often described as 'disorganized.' People, including children, usually feel better and cooperate more willingly when their meanings are understood.
5. Strengths approach to parents: A specific advantage of the DMM conceptualization is that it frames adult maladaptation in terms of parents' intention to protect their children and themselves. That is, maltreating parents were almost always exposed to danger in their childhood (cf., Crittenden & Newman, 2010). That exposure shaped their brain development in self-protective ways that over- or under-identified threat, leading to exaggerated or minimized response to threat. When these formerly adaptive perceptual and response biases are applied to new contexts and adult roles, parents can inadvertently endanger their children. For example, parents who were very harshly punished as children may punish their children too readily in a misguided effort to prevent the abuse that they themselves suffered. Other parents whose needs were neglected may have learned not to attend to feelings – because they hurt too much and were rarely assuaged by parental comfort. As parents, they may find it difficult to perceive their children's feelings and, if they notice, they may not know how to respond or may lack essential resources. In both cases, parents apply what they learned about self-protection in their childhood to protecting their children. In doing so, they may have misconstrued a safe situation as threatening, or vice versa, thus failing to protect their children (Crittenden, 2008; Gregory, 1998).
   However, many maltreating parents are also endangered in the present, for example, by family discord, violence, poverty, and illness. When parents' own well-being is compromised, they cannot be fully available to their children. Explaining parents' behaviour in this way can permit them to accept professionals' evaluation more easily. Further, such framing of the situation can guide professionals to select more effective interventions than does a focus on abusive or neglectful outcomes.
6. Change: The DMM assumes that all people can change if we create appropriate conditions. These conditions require that both parents' and children's needs be met, including especially the need to be safe.

We think these aspects of DMM theory are highly relevant to family court objectives and practice and create a basis for hope where often there is only discouragement.

A life-span set of validated assessments. Over the last three decades, a telescoping set of assessments of attachment has been developed. These permit all members of a family to be assessed with tools that use the same theory, compatible procedures, and age-salient outcome classifications. Consistent across the assessments is the use of standardized observational procedures that produce an enduring record that (1) is coded and classified 'blindly', i.e., without knowledge of the family situation, (2) can be viewed by others, (3) has specified methods for deriving conclusions, and (4) published validating data (Crittenden, Kozlowska, & Claussen, 2007). The citations below include only those with maltreating samples; many other validating studies exist using normative and clinical samples, see DMM Publications, 2012. The assessments comprise the following:

1. CARE-Index for Infants (Christopoulos, Bonvillian, & Crittenden, 1988; Ciotti, Lambruschi, Pittino, & Crittenden, 1998; Crittenden, 1981, 1985ab, 1988; Crittenden & DiLalla, 1988; DiLalla & Crittenden, 1990);
2. CARE-Index for Toddlers (Crittenden,1985ab, 1988ab, 1992);
3. Strange Situation Procedure for infants (SSP, Crittenden, 1985ab, 1988ab; Jean-Gilles & Crittenden, 1990);
4. Preschool Assessment of Attachment (PAA, Crittenden, Claussen, & Kozlowska, 2007; Jean-Gilles & Crittenden, 1990);
5. School-age Assessment of Attachment (SAA, Kwako, Noll, Trickett, & Putnam, 2010);
6. Transition to Adulthood Attachment Interview (TAAI, Crittenden, Claussen, & Sugarman, 1994);
7. Adult Attachment Interview (AAI, Seefeldt, 1997);
8. Parents Interview (PI, Crittenden, Lang, Partridge, & Claussen, 2000; Crittenden, Partridge, & Claussen, 1991).

In addition, there are several short checklists constructed to guide service planners. These include:

1. Level of Family Functioning (Crittenden, 1992, 2005);
2. Level of Parental Reasoning (Crittenden, Lang, Partridge, & Claussen, 2000);
3. Gradient of Interventions (Crittenden, 2005);
4. Severity of Maltreatment Scales (Crittenden, Claussen, & Sugarman, 1994; Crittenden & Newman, 2010).

Training and authorization of attachment experts. IASA recommends a formal course of study to train personnel to a high standard of expertise in assessing attachment for court proceedings. This will allow instructing parties to know with clarity that they are asking the most appropriate person to look at the issues.

The development of the life-span set of assessments is now completed. Courses have become available with authorised trainers in as many as 16 countries. In addition, there is a formal introductory course, a text book, and advanced clinical seminars. More recently courses are being offered on integrating the assessment outcomes with a wide array of assessments of families, including systemic assessments, parenting capacity, psychiatric and psychological assessments to yield functional formulations of the family situation and recommendations for intervention (Crittenden, 1992, 2008; Crittenden & Landini, 2011). As a consequence of these advances, designation of competence is now possible and authorized coders can improve their competence and receive higher degrees of authorization.

Professionals who train to use the tools are authorized at one of four levels of competence: preliminary, screening, coding, and forensic/clinical. IASA recommends that courts use personnel with no less than 'coder' level reliability. Professionals who present 'forensic/clinical' authorization will be required to interpret the findings. Authorization is in the form of a .pdf document, with an expiration date, that can be presented to the court.

A model protocol of a family court report

Taking all the above elements together (DMM theory, assessments, assessment courses, clinical application courses, and authorizations), IASA has made recommendations as to how a report on attachment might be written. These reports can facilitate decision-making by local authorities before proceedings are instituted and inform family court judges if proceedings are initiated. The process of developing the protocol has been interactive with family courts over several years and in four countries. Reports have been written and submitted in real cases, and then the template was refined based on feedback from judges, barristers, social services, children's guardians, parents and other caregivers. The goal has been to generate both a sound process of generating information on attachment and a helpful product.

Individuals to be assessed. The protocol calls for family level assessment of all children and all possible caregivers (kinship carers and foster parents as well as biological parents). Assessment of all adults involved as well as all children means a more extensive and possibly more expensive intervention than is currently typical. On the other hand, troubled extended family placements and failed foster placements could potentially be avoided if information about attachment and self-protective strategies were known. This would ultimately mean financial savings as well as reducing the risk to children from multiple placements. In particular, it is important that grandparents and foster carers be evaluated to ensure they will have appropriate strategies to manage the children's particular presentations. Finally, the assessments should be videotaped, even when a transcript is the basis of the coding, because observing people in interaction provides irreplaceable information.

Responsibility. Professionals using the IASA Family Court Attachment Protocol are responsible to the court and not to one side or another in an adversarial role. The expert should be as unbiased as possible, seeking only an outcome that supports the child's need for safety and comfort in a permanent home.

The components of a DMM attachment report. At present, we recommend a report with four parts.

Part 1 provides general information on attachment and the DMM model including descriptors of the specific assessments used in the report. Much of this has been written by our committee and is available as 'plug-in' descriptive developmental components (see figure 2) and 'plug-in' descriptions of the assessments indicating how they are carried out, what information they yield, and the published research relevant to their validity (see figure 3; Farnfield, Hautamäki, Sahhar, & Nørbech, 2010).

Part 2 of the report provides detailed information about the results of each assessment for each person who was assessed. This section is written uniquely for each person. It begins with a description of the uninterpreted results of the assessment, proceeds to provide evidence relevant to deriving meaning from the assessment, and concludes with the formal result, together with a discussion of the strengths and limitations of the individual and acknowledgment of questions that remain unanswered.

Part 3 provides a brief summation of the background material (history and reports of other experts) and identifies points of confirmation and discrepancy between the attachment assessment and the other assessment data. Where there are discrepancies, these are fully discussed and possible explanations explored. The family situation is then formulated, taking everything known into account. When the formulation is developed carefully, with consideration of each person's experience, perspective, intentions, and actions, it is usually accepted by all readers, both professional and familial. Part 3 concludes with recommendations for services that are tied to the competencies, strengths, limitations, and needs of family members. The recommendations are structured developmentally. That is, if a parents has certain competencies and is ready to acquire specific others, but the child needs

the parent to have more complex skills, ways to bridge the gap are sought. The developmental issue of whether the child can wait for the parent to acquire the essential competencies is central. Addressing this question is a crucial aspect of the attachment report. If the child cannot, then alternate caregivers will be needed together with a plan for maintaining contact with the parents.

Part 4 uses all that has preceded it to provide succinct answers to the specific questions posed in the letter of instruction. It is followed by appendices as needed.

Varied approaches to generating DMM attachment reports. The protocol allows for several levels of expertise and authorization.

1. DMM-informed reports. We suggest that the least skilled attachment experts function as coders only, working with court-selected experts. These coders submit their classification to the court appointed expert who received the letter of instruction and who develops the functional formulation, integrates the attachment results into the expert's full report, and responds to the court's questions. In these cases, several coders may be used for different assessments or individuals.
2. DMM-formulated reports. Alternatively, the authorized attachment expert may classify all the assessments, read the history and write the functional formulation, but do so for inclusion within another expert's report. For example, the expert assigned to evaluate parenting capacity may include the report on attachment within his or her report. In this case, the recommendations are made by the professional who received the letter of instruction and, later, the attachment report.
3. DMM Family Attachment Reports. In the fullest attachment report, the authorized attachment expert receives a letter of instruction, codes the assessments, and writes the report and recommendations independently; this provides the highest level of integration around DMM ideas.

IASA's webpage (www.iasa-dmm.org) has a page specifically for court personnel describing the DMM protocol and listing authorized individuals who can implement the protocol.

Advantages of this protocol

We think that this protocol offers several advantages that we summarize here briefly.

1. It provides a careful progression from facts to interpretation to recommendations.
2. The process is visible to readers (the court, other professionals and family members) and replicable by other experts.
3. The ideas are easily grasped by professionals from other disciplines and by parents.
4. The differentiation of behaviour and information processing facilitates the tailoring of treatment to individual and family conditions and needs.
5. This permits personalized, targeted education, psychotherapy, and pharmacotherapy.
6. It permits specification of counter-recommended treatment approaches, thus, reducing the potential for iatrogenic harm.
7. Responsibility for outcomes is distributed among family members, community support, and professionals' decisions and actions.
8. Including professionals highlights where professionals can more fully support family functioning, thus, making positive outcomes more likely than if all change were seen to be a family responsibility.

Limitations and next steps

The DMM protocol is ambitious. It will require more people involved in assessments, more expectations on families to participate in formal assessments and probably more expense. On the other hand, changes can occur more rapidly when goals are stated explicitly and examples of how to reach them are provided. But most importantly it will happen if the

stated goals are viewed as valuable by the people seeking assessments. IASA thinks the protocol is sufficiently developed to be offered for comment by professionals of all disciplines working in the field. The hope is that doing so will further enhance the interactive process that has generated the protocol up to now.

Limitations. A current limitation is the insufficient supply of skilled and authorized coders. Efforts are being made to refine the skills of existing coders. Acceptance of the protocol and an increasing demand for the assessments will naturally lead to more professionals taking the training courses and qualifying for authorization. This will increase capacity.

In addition there is a need for continuing published research into the validity of the assessments, particularly the newer assessments that have a more limited database.

Although a full DMM assessment is expensive, the resulting outcome may actually reduce total financial costs. Thorough assessment with recommendations for effective interventions can reduce costs in a number of ways. Court proceedings may be avoided altogether if families have appropriate supports targeted at their specific needs. Children who do need out-of-home care can be placed with people who are best able to meet their needs and avoid placement breakdown (Crittenden & Farnfield, 2007). Finally, children who had been failing in care may be moved to better matched carers or their carers or parents helped to resolve the children's problems. In summary, experience of using these attachment tools in the specified protocol is that it often yields novel solutions, achieves agreement among disputing parties, and reduces total financial costs. Most importantly it can lead to better outcomes for children.

Next steps. Our next steps are to make the descriptive materials available to court personnel through IASA's webpage (www.iasa-dmm.org). In a series of conferences and workshops, examples of DMM attachment assessments will be presented so that professionals can see how these ideas are actually applied. Feedback will also be sought to further develop the protocol.

Our priority now is establishing a corps of authorized coders for multiple assessments. Among these are professionals who already have experience working as experts for the courts with the authority to formulate cases. This process is well under way in the UK, partially accomplished in Italy, and slowly spreading to other parts of Europe and other continents. Trainers are being authorized and seminars and retests are being offered to enable coders to improve their authorization level. As coders become authorized, they will be identified on the website. To insure that the protocol itself improves, methods will be developed to track outcomes for assessed families to determine the efficacy of recommendations with the feedback used to refine the protocol.

Figure 1. Adult attachment strategies and associated information processing.

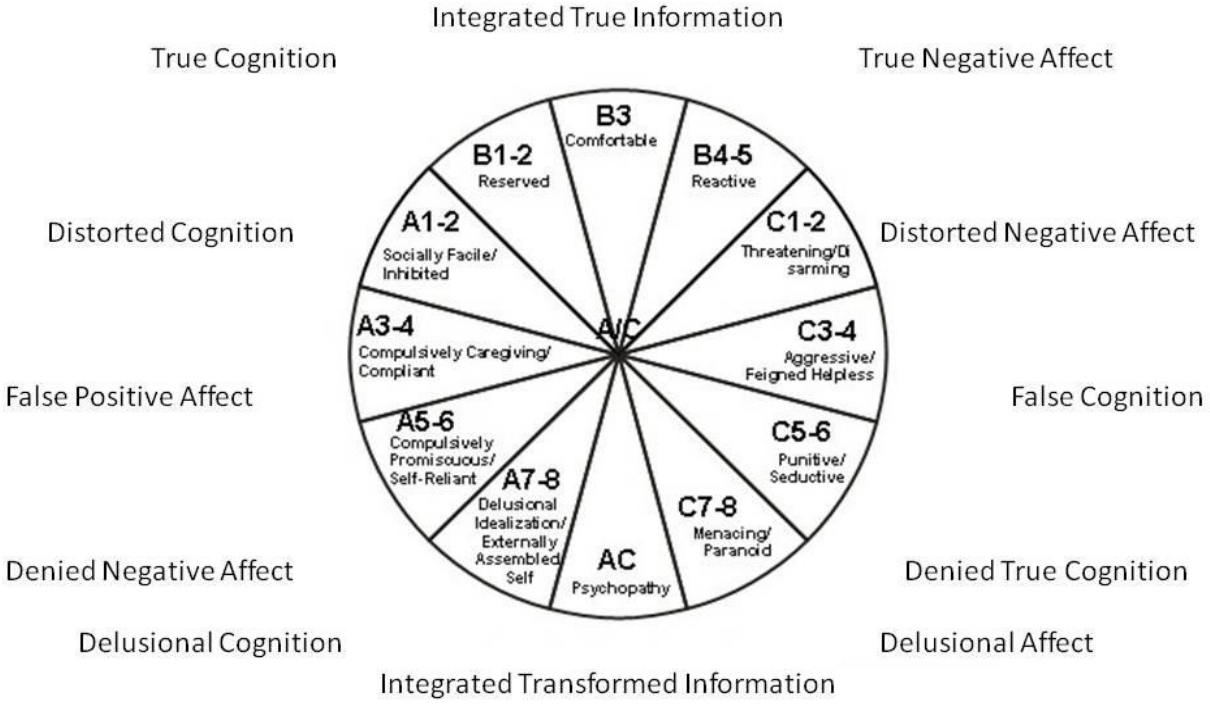

Figure 2. Example of a ‘plug-in’ descriptive developmental component.

Adulthood. Several competencies differentiate adult attachment from attachment in the transition to adulthood. Overall, they could be described as achieving ‘clarity’ and ‘balance’ for the function of raising children. For example, adults can differentiate needs from desires; because children cannot, adults must decide whether a child’s demand (e.g., for comfort or protection) needs a response or is merely a desire. Similarly, adults can consider the needs and desires of several family members simultaneously and reach decisions about which to prioritize at any particular moment. It is particularly important to note that all family members (including parents) have needs and as much as possible, needs should be met. Balance is the issue; that is, distributing the family’s resources as productively (as opposed to ‘equitably’) as possible. Adults can foresee consequences in the long-term, thus acting in the present in ways that will have long-term positive consequences for children. Children, and frequently adolescents, cannot do this. Adults form long-term committed attachment relationships. These relationships are mutually protective and comforting. Adult partners build conflict resolution skills that, together with their emotional commitment to one another, sustain the relationship through difficult periods. Finally, adults use these competencies to generate the resources to care for their children until they reach reproductive maturity.

Adults who were at risk in childhood have the possibility to use balanced reflective functioning (a late developing cortical process, not complete until the mid-thirties) in adulthood. Balanced reflective functioning can override the distorted neurological pathways (laid down in childhood) that lead to extreme self-protective behaviour. Being able to do this, however, requires: (1) a period of reorganization (that usually begins in the transition to adulthood), (2) sufficient time to engage in reflective thought, (3) a stable life context that prevents crises (real or imagined) from catapulting one into self-protective action prior to reflection, (4) practice, such that new response pathways are laid down, and (5) gentle tolerance of mistakes - because mistakes are certain and punitive responses lead to increased self-protective behaviour. The choice of attachment partner is crucial to being able to achieve stability and forgiving tolerance of mistakes.

In cases of adult risk, adults have children without having the competencies described above. Being unclear about circumstances, they necessarily act in ways that are not protective and comforting, sometimes even endangering their children, each other, or themselves. Being unable to differentiate needs from desires and long-term benefits from short-term preferences, they often mis-direct their efforts. Being unable to manage competing needs, they often favour one person’s needs over another’s, either prioritizing the children, their spouse, or themselves, but failing to find a balance that promotes everyone’s development..When adults cannot process information to yield clarity of understanding and balanced responses, whole families are placed at risk.

Figure 3. Example of a 'plug-in' description of the assessments indicating how they are carried out, what information they yield, and what information they cannot provide.

The Preschool Assessment of Attachment

The PAA assesses a child's self-protective strategy in an attachment relationship, indicating (1) whether the child identifies the parent as a source of danger or protection or both and (2) what strategy he or she uses for self- protection. Based on published studies (see below), the PAA is currently the best assessment of attachment in 2-5 year old children with evidence that it differentiates maltreated and emotionally troubled children as well as children of troubled mothers from more normally developing children.

The DMM is particularly sensitive to nuances of attachment behaviour in high risk contexts. Consequently, as the degree of risk increases, there is a corresponding decrease in the number of children classified as securely attached. This reduces the proportion of 'false secures' found with other methods of assessing attachment.

The PAA uses the modified Strange Situation Procedure that accommodates children's ability to walk, talk, and open doors. In the PAA, the parent/caretaker and the child are in an unfamiliar setting suited for videotaping. The dyad is taken through eight 3-minute episodes which gradually increase the amount of stress, thus eliciting the child's attachment strategy, culminating in a 3-minute period when the child is left entirely alone. The behaviour of the child in threatening moments (separations from the attachment figure) and in moments when support is available (the primary attachment figure or a surrogate attachment figure) reveals the child's self-protective strategy.

The results are specific to the attachment figure in the procedure and children often have different strategies with different parents. The primary limitation of the PAA is that it gives limited understanding of the adult's behaviour.

Like all assessments of attachment, the PAA must be classified 'blindly', but interpreted clinically in the light of the history and assessments of the attachment figure. Securely attached children both manage their own feelings well and also call for and/or welcome the parent back upon reunion. Anxiously attached children either (1) ignore the parents' departure and return or (2) make excessive demands upon the parent during departure and reunion. Children at risk can also show (3) extreme forms of the patterns, (4) combinations of the two patterns or (5) appear depressed and helpless in the face of danger. Children who have experienced out-of-home placement often show especially cautious strategies as though afraid to seek closeness or display desire for comfort.

A PAA yields the following types of information:

1. The child's attachment strategy with this particular adult.
2. The possibility of an overriding distortion of the strategy or an indication that the strategy is not functioning effectively for the child such as unresolved trauma, loss or depression in the child.

A PAA cannot determine whether or not a child is attached, nor how 'strong' the attachment is.

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