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A Dynamic-Maturational Model (DMM) Approach to Psychotherapy, Parental Care and Forensic Assessment

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Abstract

The innovations introduced by the Dynamic-Maturational Model of attachment and adaptation (DMM) are extremely useful for the understanding of the clinical process and particularly compatible with the dynamic approach to psychotherapy, parental care and forensic assessment. The DMM follows a biopsychosocial perspective and analyses clinical problems in terms of attachment strategies in relation to the context and the specific types of danger, considering patient's and therapist's attachment patterns and their interactions. The DMM serves as a useful framework in guiding verbal and nonverbal intervention (questions, observations, reformulations, interpretations, self-disclosure, empathic validation of the patient's emotional responses) in individual, couple and family dynamic psychotherapy. Attachment assessment tools in the DMM are relational experiences and have an implicit clinical value by fostering therapeutic alliance. Some of these can be used as part of a DMM-based Parent Training which integrates psychodynamic and psycho-educational interventions (including the use of the CARE-Index as a video-feedback tool). The clinician tends to be more active than in a classical psychoanalytic approach and different techniques can be integrated by the same therapist or by different therapists in a tailored treatment based on the patient's needs. A specific IASA Family Attachment Court Protocol based on DMM was presented.

Keywords: Attachment; Dynamic-Maturational Model; DMM; Psychotherapy; Parental care; Forensic; IASA, Family attachment court protocol

The Dynamic-Maturational Model

The Dynamic-Maturational Model of attachment and adaptation (DMM) [1,2] is an integrative theory considering the contributions of psychoanalysis, general and family systems theory, developmental psychology, cognitive psychology, neuroscience, evolutionary theory and anthropology.

The basic features of the DMM include:

i. **An evolutionistic perspective:** human behavior is studied in terms of natural selection and adaptation and in relation to the life cycle of individuals and their families. The problems are addressed by studying the functions of defensive behavior in different contexts, especially considering past and present family relations.

ii. **A biopsychosocial perspective [3,4]:** DMM fits people within their own systems and subsystems, considering different levels of systems (genetic, developmental, neuropsychological, medical, psychological, individual, familiar, social, cultural) [5].

iii. Emphasis is on the necessity to protect from danger, rather than on secure base concept [6], developmental change and self-protective organization in response to fear are underlined.

iv. The assessment is based on specific assessment tools for every age: CARE-Index, the Strange Situation (DMM/SS), the Preschool Assessment of Attachment (PAA), the School-age Assessment of Attachment (SAA), the Transition to Adulthood Attachment Interview (TAAI), the DMM/Adult Attachment Interview (DMM/AAI) and The Parents Interview (for a review

see [7]).

v. An expanded array of self-protective strategies for children and adults is proposed, based on developmental extensions of Ainsworth's infant Type A (dismissing), B (secure/balanced), and C (preoccupied) patterns of attachment, including high index patterns (A 3-8 and C3-8) and mixed patterns (A/C, AC). The expression of attachment patterns may be altered by the presence of modifiers (such as depression, disorientation, intrusion of forbidden negative effects, expression of somatic signs) and by unresolved trauma or loss; these are an index of the global adaptation to the current context. Furthermore, attachment patterns can change in life (reorganization) as a result of maturation or significant experiences, dangerous and protective ones, in particular. Patterns differs in the use of cognitive information (logical, based on temporal contingences and causal attributions) and affective information (emotional, based on intensity of perception): individuals using the Type A patterns favour cognitive information and inhibit or falsify affective information; individuals using the Type C patterns favour affective information and omit or falsify cognitive ones. Individuals using a Type B pattern integrate cognitive and affective information fluidly, as the context requires.

One advantage of the DMM is that it considers three distinct levels of human functioning, each amenable to different interventions:

i. The distortion of thoughts and affect (which can lead to alterations in behaviour);

ii. Relational aspects (family and attachment relationships, in particular)

iii. The strategies for self, partner, and child protection from danger.

The DMM assessments are relational experiences that provide information on the patient's attachment pattern. Often, they offer a first opportunity for insight and for the development of a therapeutic alliance. The DMM offers a framework of individual and family development and adaptation that can function as a guide for the organization of prevention and treatment. In particular, the innovations introduced by this model are compatible with a dynamic long-term or short-term psychotherapy (DMM-based Dynamic Psychotherapy) [8-11] and for parental care and interventions with couples and families [12].

According to Peter Fonagy [13, p.2] "one of the many valuable contributions of Dynamic-Maturational Model (DMM) of attachment and adaptation is its firm re-engagement with the evolutionary approach that underpinned Bowlby's original thinking".

Assessment of Problems

The DMM analyses clinical problems in terms of strategies of attachment and relationship with the environment. Considering the pattern of the patient, what are his ways of relating to others (especially with the clinician)? What makes him feel safe and what makes him insecure (or activates his protection strategies)? What danger did he face in the past and what are the current situations in which he may be in danger? In particular, the DMM is valuable for the recognition and treatment of psychological disorders resulting from unresolved traumas and losses [14-17]. These conditions can lead to intense traumatic reactions of anxiety and alarm, or they can be dismissed through inhibition of negative affects that accompany them (anger, fear, vulnerability), to the point of being blocked out in cases where the patient cannot tolerate thinking about his own experience. In cases of preoccupied trauma or bereavement, therapeutic mentalizing strategies are useful to improve emotions regulation [18]. When the reaction is dismissing, cognitive-behavioral treatments should be avoided, and care should be focused on the expression of inhibited negative affect [19].

As noted by Bowlby [6], patterns and behaviors of the patient cannot be considered healthy or pathological in themselves but, rather, appropriate or inappropriate given the specific context in which they are applied. Many insecure patterns have in the past played a protective role in the environment in which they developed, although they may be inadequate in the current context. Psychopathology, in this perspective, is the result of inadequate self-protection strategies in relation to the context in which they are expressed. This focus on the adaptive function of attachment strategies allows explanation of the development and maintenance of psychopathological disorders while enabling clinicians to avoid taking moralistic or socially discriminating positions against patients.

The attachment strategies of the patient and the clinician

The DMM pays attention to the patterns of attachment of the patient and the therapist and considers the various interactions between the two. By analysing the patient's attachment configuration, the therapist may organize the most appropriate relational and therapeutic interventions (including interpretations), considering the patient's specific ability to process cognitive and affective information [20-22]. A patient using a Type A strategy, for example, must be respected in his need to receive clear information and organize thoughts in a relatively rational way, but also be helped in the expression of emotions, especially negative ones. Alternatively, a patient using a Type C strategy requires that the therapist is more careful not to collude with his mental state and acts more firmly and maintains constant psychological containment to improve the regulation of emotions and their related somatic signs [23,19]. In these cases, it will be useful to provide the patient with a steady and predictable setting and precise rules of the interaction.

The relational style of the therapist, therefore, can be organized in a relatively "complementary" way to the patient's,

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by avoiding, especially at the start of the therapy, exposing him too early to anxiety-provoking or overly confusing experiences. The attachment strategies of clinicians, however, tend to differ from those of the general population, with a higher proportion of insecure styles and unresolved traumas or losses (such as illness or death of a family member). These features may be the basis of their motivation to choose a helping profession [24-26], but they inevitably influence the clinical relationship. In particular, a therapist with a Type B strategy will be more able to modify his behavior depending on the characteristics and needs of the patient, while therapists using Type A or C strategies might be relatively adequate only in treatment of patients with opposite attachment configurations, as a partial compensation of the respective ability to treat cognitive and affective information occurs (Figure 1).

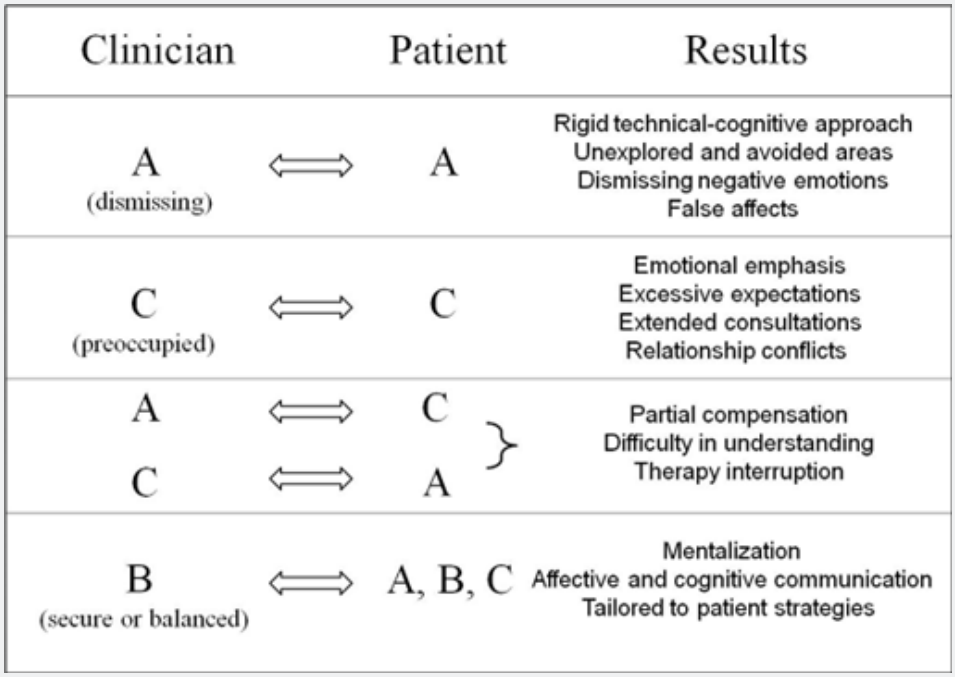

Figure 1: Matches of attachment patterns in clinical setting.

When a therapist using a Type A strategy meets a patient with the same characteristics, their attachment strategies may negatively overlap and the relationship will tend to be characterized by: more directive interventions focused on rational aspects (rigid technical-cognitive approach, cognitive-behavioral prescriptions, intellectual explanations of disorders, focusing on the somatic dimension), avoidance of problematic areas that remain poorly explored (relational problems, depression, fantasies of death or suicidality, unresolved losses or traumas); systematic dismissing of negative emotions with the tendency for both to express false positive affects (such as smiling or joking when facing painful or scary topics). When a therapist using a Type C strategy relates to a patient with the same pattern of attachment, there may be collusion between the two attitudes, with the tendency for both to emphasize emotions and foster unrealistic expectations of treatment. In these cases, it will be difficult to maintain relationships within proper limits, and consultations may extend after set times. At the beginning of the therapy patient and clinician will also have the impression of being on the same wavelength (as if they were friends), but, over time, intense transference neurosis may appear (due to disappointment of mutual expectations), with critical reactions, provocations, relational conflicts and possible interruption of therapy.

When an insecure psychotherapist meets with a patient with opposite characteristics, however, a partial compensation can occur. Studies have shown, in fact, that this condition is often related to a satisfactory therapeutic relationship, especially if the therapist is dismissing [27]. But countertransference enactments may also occur, along with omissions and misunderstandings concerning the neglected or problematic areas of mutual attachment styles (such as affectivity for dismissing subjects and cognition for preoccupied), with the consequence that difficulties arise in understanding and sharing. One of the consequences may be poor therapeutic compliance or even abrupt withdrawal from treatment.

Research has shown that a therapeutic attitude which is complementary to the attachment style of the patient is particularly important at the beginning of treatment and is positive only if it takes the meaning of a conscious gratification of the patient's transferential needs, encouraging a valid working alliance [28]. With time, however, it can become a collusive

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relational mode leading to avoidance of problematic areas [29]. A secure/balanced psychotherapist (Type B), however, integrating mentalization, cognitive information, affects and communicative skills with a good ability to analyze problems, will address the therapeutic relationship in a more conscious way and will work to adapt better to the patient's style of attachment [27,30,31].

In the case where a patient with a secure attachment addresses an insecure clinician, however, he will try to facilitate the task of the therapist, compensating for the latter's limitations and enhancing his skills. Meta-analyses of research literature, in fact, have shown that patient security is related to the development of a valid therapeutic alliance [32]. When the therapeutic relationship is not satisfactory, however, patients have no difficulty in turning to another therapist.

Caring and raising parents

Based on video recording of spontaneous interaction between child and adult, the CARE-Index [33] can be used as a video-feedback technique in therapies of families at high risk (children with somatic disorders or preterm birth, teen mothers, psychiatric or drug-addicted parents, abusive families, or problematic foster families) [2,34,35]. Watching the video, accompanied by comments, suggestions and encouragement of the therapist, promotes parents' reflective skills and sensitivity, helping them to adopt more appropriate attitudes with their partner and their child. This promotes the couple's mental and relational well-being and, in a transgenerational perspective, confers long-term positive benefits on the development of the child. A specific DMM-based Parent Training is possible, integrating psychodynamic interventions with psychoeducational techniques (including the possible use of video-feedback tools). A growing number of parents are directed to a psychologist to help them understand their children. In many cases they feel upset and angry as they have been tormented by the child's capricious and coercive behaviors, or they feel guilty because they failed in their attempts to educate them. Their children often have behavior problems at home or at school. Many of these children are likely to receive a psychiatric diagnosis and to be subjected to pharmacological treatment. To help these parents attribute non-pathological meaning to their children's and their own behaviour is paramount. A disturbed or disturbing behavior may be an attempt to adapt to an environment where parents (and other adults, such as grandparents or teachers) are inconsistent, contradictory and unpredictable (sometimes absent, sometimes overprotective). Clarifying to parents that they are the main caregiver for their children empowers them and reduces the tendency to delegate their duties to others. It is often possible through education to help parents to recognize the importance of a more consistent parenting style, teaching them not to argue in front of children and not to promise things that they cannot fulfill (such as rewards and punishments). Often this requires interventions that enhance the couple's life and help them deal with relationship conflicts (even with their families of origin) [12]. A child who perceives his parents as present and sensitive, yet clear, firm and authoritative, feels secure and encouraged in facing life's challenges.

Clinical Use of the Adult Attachment Interview

The administration and coding of the Adult Attachment Interview (AAI) according to the DMM criteria [36,37] makes it a valuable tool for dynamic psychotherapy of adults [38,15,39], adolescents, children [12] and in Family Court decisions [17]. In addition to the intrinsic and non-specific therapeutic aspects of the procedure (to relate, tell, acknowledge discrepancies, communicate emotions, empathic listening by the interviewer) [40], the report of the AAI classification to the patient (in a simple and understandable way) provides him a valuable opportunity to redefine his problems and motivate him to undertake a treatment, fostering a therapeutic alliance. The AAI allows to specify the attachment pattern of the patient and his strategies to protect from danger. This guides the therapist in the choice of the most effective clinical attitudes and words to be used with the patient.

A clinical assessment that uses the AAI can be organized in this way:

i. An initial clinical interview, after which the patient is offered the AAI;

ii. A second meeting where the AAI is administered;

iii. A third meeting for clinical discussion and possible indications for treatment.

A similar setting can also be used in treatment of couples or intervention on parents. In this case, four meetings are necessary, two of which are reserved for individual administration of the AAI to each member of the couple. In parental assessment, AAI helps us to understand the parent's patterns of psychological information processing and their underlying self-protective strategy when relating to their children and the partner [41].

Therapeutic Technique

Regarding the therapeutic technique to be used in short- or long-term dynamic treatments, the DMM proves a valuable guide in formulating verbal interventions (questions, comments, reformulations, interpretations, self-disclosure). In particular, interpretations are possible that help the patient to recognize the adaptive significance of his behaviors and defensive strategies, particularly those in situations of danger in the past and in present life (including the therapeutic experience). The interpretation must be accompanied by an empathic validation of the patient's emotional responses (anger, fear, feelings of helplessness and vulnerability), which, led back to the original context, can be better understood, making him feel less sick and guilty. These interventions are important for patients who present unresolved trauma or loss, or for those who have suffered deprivation, neglect and abuse in the past [14,15].

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In the treatment of severe patients, however, in line with data from the most recent psychodynamic literature, less emphasis is placed on interpretation, in favor of other instruments such as countertransference processing and analysis of relational dynamics, paying close attention to mentalization, constancy of the setting and non-verbal behavior. These actions, to be effective, require spontaneity and authenticity, as they are based on the therapist's procedural skills. Facial expressions and body language attuned with the mental states of the patient play a key role in the treatment plan, even when the patient's states are masked or falsified by his behavior (e.g. smiles when talking about a painful or scary subject). The same is true when someone with a gesture (a movement of the hand, a body contact, a look) expresses an understanding of a state of mind, even when not communicated verbally or in turn-taking during communication. These non-verbal elements are based on implicit mentalization (i.e. the more spontaneous and authentic way to mentalize) and are analogous to the attunement between musicians during improvisation (such as in jazz) [42].

Integrate and Customize Treatments

For adequate care, the DMM considers the possibility to integrate different interventions such as psychoanalytic, cognitive, behavioral and systemic. Therefore, the therapist tends to assume a more active role than in classical psychoanalysis. The various techniques can be used by the same therapist or different therapists within an integrated treatment protocol. The goal is to offer a tailored care according to the characteristics of the patient: age, past and present history, attachment pattern and defensive strategies, any unresolved traumas or losses, mentalization skills, what makes him feel insecure, the current conditions of danger, adaptability, family and socio-cultural relational context (work, economic conditions, level of education, belonging to specific ethnic groups, or possible marginalization).

DMM in Forensic Field

In April 2007 in Newcastle, UK, the International Association for the Study of Attachment IASA (www.iasa-dmm.org) was founded that brings together all clinicians and researchers who recognize themselves in DMM. International IASA's congresses were held in Bertinoro (IT, 2008), Cambridge (UK, 2010), Frankfurt (DE, 2012), Miami (USA, 2015) and Florence (IT, 2018). The IASA's 10-Year Celebration was held in Florence, June 2018, hosted in the Institute of Family Therapy directed by the late Rodolfo de Bernart, co-Chair IASA. A particularly interesting section of the conference was dedicated to the use of the DMM in the forensic field and some special issues of DMM News (the electronic journal of the IASA directed by me from 2012 to 2019) were dedicated to the IASA Family Attachment Court Protocol drawn directly from the IASA's 10-Year Celebration [43-48 and DMM News n. 26-29, 2018].

Conclusion

DMM is an important theory that has informed different therapeutic models (including psychoanalytic ones), particularly in the assessment of problems and identification of defensive strategies. At the same time, many DMM-trained clinicians are working in the direction of a DMM-based psychotherapy, integrating different techniques and devising original interventions tailored on the patient's and family's features analysed from a DMM perspective. See, for example, the important Attachment and Family Therapy [12] and an interesting book by Chris Baim and Tony Morrison [46], a manual (including examples, exercises and audio files) on how to develop a therapeutic intervention for adults based on DMM information. Research needs to be conducted on efficacy (to prove that a specific treatment acts on a specific disorder excluding the influence of other factors) and on effectiveness (to assess the outcome of psychotherapeutic methods as are used in actual clinical settings) of these DMM-based treatments.

Table 1 sets out the main differences in dynamic psychotherapy among the contemporary psychoanalytic model, the A-B-C+D attachment model (adopting the classification of Ainsworth in childhood and Main, Goldwyn and Hesse in adulthood) and the DMM [see also 37].

Table 1: Comparing models in Dynamic Psychotherapy.

	Contemporary Psychoanalysis	Attachment A-B-C+D	Attachment DMM
Key concepts	Relationship. unconscious. transference, countertransference, conflicts, resistances. defenses (less importance of drives)	Attachment relationships, secure base, IWM. mentalization	Danger. adaptation. cognition. affect. memory systems, patterns, self-protective strategies, multiple dispositional representations
Motivations	Meeting the needs, limiting suffering	Searching for Safety	Protection from danger, reproduction
Models	Conflict. symbol, personality structure	Secure and insecure attachment. IWM: A-B-C+D / Ds-F-E-U	Pattern: A-B-C. low and high index. mixed patterns, modifiers

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Defenses	Neurotic or primitive	Attachment behaviors. defensive exclusion ambivalence	Strategies for self-protection from danger
Pathology	Psycho-neurosis, perversion, personality disorders, psychosis	Dysfunctional attachment. loss. trauma	Dysfunctional adaptation. U/Tr. U/I, Modifiers (Dp. DO. ina. less)
Assessment	Clinical interview, projective tests, Manual: PDM. OPD	Clinical interview. SS. AAI, Self-report questionnaires	Clinical interview. CARE-Index. SS. PAA, SAA, TAAI, AAI. PI
Technique	Analysis: free associations. dreams. paraprax-es, resistance and transference Processing of countertransference Focus on non-verbal and setting Empathic attitude Interpretation (less important in severe patients)	Promote a secure base Encourage exploration Identify the IWM Analysis of transference and of attachment behaviors Interpretation Mentalization	Different theories (psychoanalysis, evolution theory. systemic cognitivism behaviorism neuroscience) Different techniques (free associations, questions, interpretation reformulations, CBT) Study of defensive strategies according to family context and specific conditions of danger Tailored therapy according to age. pattern and strategies for self-protection
Therapist	Less active	More active	More active

In conclusion, the DMM approach places the individual and his family in their context and in the life span, considering the function of human behavior (normal or pathological) and the specific way cognitive and affective information are processed to protect from danger and suffering and to improve adaptation. These characteristics are distinctive from other attachment-based theoretical models and offer health care professionals and psychotherapists important information for the analysis of clinical problems and the organization of treatment.

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