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Introduction to the Dynamic-Maturational Model of Attachment and Adaptation: A Function-Based Approach to Understanding Developmental Psychopathology

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ABSTRACT

This article introduces the Dynamic-Maturational Model (DMM) of attachment and adaptation (Crittenden, 2016; Crittenden, & Landini, 2011; Crittenden et al., 2021), a contemporary and well-researched model of attachment that is particularly relevant to practitioners who work with children, adults and families in social work, social care, mental health, child care, fostering and adoption, criminal justice and related settings. This article explains how attachment theory can inform our understanding of human behaviour in situations of stress, threat or danger, and how to understand individuals whose behaviour is problematic or who may become a danger to themselves or others.

Introducción al Modelo Dinámico-Maduracional del Apego y la Adaptación: un Enfoque Basado en Funciones para Comprender la Psicopatología del Desarrollo

Palabras clave:
Apego
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RESUMEN

Este artículo presenta el Modelo Dinámico-Maduracional (DMM) de apego y adaptación (Crittenden, 2016; Crittenden y Landini, 2011; Crittenden et al., 2021), un modelo contemporáneo y bien investigado de apego que es particularmente relevante para los profesionales que trabajan con niños, adultos y familias en trabajo social, asistencia social, salud mental, cuidado infantil, acogida y adopción, justicia penal y entornos relacionados. Este artículo explica cómo la teoría del apego puede informar nuestra comprensión del comportamiento humano en situaciones de estrés, amenaza o peligro, y cómo comprender a las personas cuyo comportamiento es problemático o que pueden convertirse en un peligro para sí mismas o para los demás.

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Attachment and Human Development

Attachment theory provides a model for understanding the self-protective strategies we use throughout our lifespan to survive and maintain a sense of safety. Early empirical research in the field of attachment focused primarily on how early experiences of care – including problematic or harmful care – influence the development of our strategies for gaining protection and comfort (Ainsworth, 1985; Ainsworth & Bowlby, 1991; Ainsworth et al., 1978; Bowlby, 1995, 2000; Crittenden et al., 2014; Landini et al., 2015). More recent research has shown that attachment strategies are important and relevant across the whole of the lifespan and in all human societies (Allam & Baim, 2017; Crittenden et al., 2021; Dallos & Vetere, 2021; Howe, 2011a, 2011b; Landa & Duschinsky, 2013a). Attachment theory is therefore just as important for understanding adult attachment as it is for understanding children's.

Attachment theory has a lot to offer professionals who work with children, adults and families who are under stress, in crisis or behave in ways that are problematic or unsafe. By looking at a client's history, carefully listening to the ways in which they talk about their lives and their struggles, and assessing their current strategies of self-protection (that is, their attachment strategies), professionals can make more accurate assessments and formulate plans that are more likely to help people make needed changes and access support (Crittenden & Spieker, 2023; Crittenden et al., 2024; Spieker et al., 2021).

Understanding attachment patterns can also help practitioners to more readily identify the behaviour patterns that the client uses to maintain safety and comfort and which also, in some cases, serve to keep the client stuck in behaviour that no longer serves them as adults. The task is then to help the person understand when and how they are using the strategy, and to help them to develop other strategies more suited to their current situation (Baim & Guthrie, 2014).

Through careful and empathic listening, the worker may help the client to look at their story with new hope and determination. This is powerful and transformative work. Such an approach means that workers can improve the quality of the helping relationship and improve outcomes for vulnerable adults, children and families. It is an approach that makes personalisation, choice and control a more realistic hope for many people.

Attachment and Basic Survival Strategies

From birth, human infants (and most other mammals) display a range of instinctive behaviours to signal when they are afraid, hungry, tired, cold, hot, in pain or otherwise unsettled. When distressed, the infant will instinctively cry, cling and reach out towards the (hopefully) protective person, that is, an attachment figure. These actions attempt to meet four basic survival needs:

- Faced with perceived *danger*, we seek *safety*.
- Faced with perceived *distress*, we seek *comfort*.
- Faced with perceived *isolation*, we seek *proximity* to our attachment figure(s).
- Faced with perceived *chaos,* including internal chaos, we seek *predictability*, that is, what is familiar to us.

Thus, the term *attachment* refers to several related processes: staying *safe*, seeking *comfort*, regulating *proximity* in relation to attachment figures, and seeking *predictability* (Crittenden, 2016).

The strategies that an infant learns to use with their attachment figures arise from their instinct to adapt, which is as important as their instinct to attach. Seen in this way, we can see that patterns of attachment develop within the context of thousands of everyday interactions between the infant and their attachment figure(s). The attachment behaviour of the infant is their best solution for obtaining the protection and comfort they need, from the particular attachment figure(s) they depend on.

The process is personal, interpersonal and adaptive; the ways in which the attachment figure does or does not respond to the infant's signals of distress will create the early template for how the infant learns to recognise and regulate their emotions and interact with their attachment figures (Howe, 2005; Gerhardt, 2004; Fonagy, 2001). These early experiences and patterns of response typically become deeply embedded within the neural pathways of the brain and the central nervous system (Eagleman, 2016; Siegel, 1999; van der Kolk, 2014; Panksepp, 2005; Perry, 2008). This is why our early attachment patterns impact so profoundly on our later abilities to regulate our emotions within the context of relationships, particularly intimate and sexual relationships.

In adulthood, we may use the same self-protective strategies that we used as children. This can help us to understand why, for example, an adult being abused in a relationship may not realise they are being harmed; they may not see the abuse as harmful, and indeed they may even find some safety in the predictability of the violence or abuse. If the situation is predictable, at least they can organise a strategy to survive within it – a strategy that has kept them alive so far.

The Dynamic-Maturational Model

Crittenden (2016), a former doctoral student of Mary Ainsworth, has developed a range of attachment assessments that apply across the lifespan. This has led to her development of the Dynamic-Maturational Model of attachment and adaptation (DMM), a name that reflects the dynamic and developing potential of adaptive strategies within each person, across their lifespan (Crittenden & Baim, 2017; Crittenden & Landini, 2011; Crittenden et al., 2021b; Farnfield et al., 2010).

The DMM deliberately avoids using clinical categories or labels. Instead, the DMM considers attachment strategies as serving a crucial survival function in their original time and context and considers these strategies on a continuum of attachment security. In this way, the DMM can be seen as a strengths-based, non-labelling and non-pathologising model. It does not focus on symptom-based diagnoses but instead concentrates on *understanding* the function and meaning of human behaviour. Based on the DMM's rigorous empirical support and scientific validity (Crittenden et al., 2021c), it is likely to play an expanding role in our understanding of human development and psychopathology. The DMM is taught internationally, including in the UK and Ireland, and has been validated in a wide range of studies and described in more than 500 publications. The research continues in more than 20 countries with many different populations.

Typically, those who face serious and chronic dangers in childhood and are unprotected and uncomforted must adapt their mental processing and behavioural responses to cope with such

dangers (Crittenden and Landini, 2011; Crittenden, 2002; Dallos et al, 2020; de Zulueta, 1993; Schore, 2003). The DMM stresses that the strategies, when first developed in childhood, were adaptive in that they promoted the child's survival at that time. It is only later that the use of these same strategies may become maladaptive, that is, used out of their original context.

For example, a child who compulsively complies with the demands of an abusive parent is simply doing their best to survive; the compulsively compliant strategy is keeping them alive. However, if they still use a compulsively compliant strategy in adult relationships, they can easily fall into relationships where they are exploited, victimised or otherwise abused, and they may have no strategies for escape or even an awareness that things could be different for them.

This is crucial to our understanding of psychological disturbance: The very same strategy that is adaptive in infancy, childhood or adolescence may be maladaptive later in life. This is a key insight from attachment theory, and it reminds us that as practitioners we must never have in mind that we are 'treating' a strategy. Instead, we recognise the value of that strategy in keeping the person alive when they faced significant dangers, and we help them avoid over-applying that strategy while at the same time helping them to *add to their repertoire of strategies* (Baim & Morrison, 2023; Cozolino, 2002; van der Kolk, 2014).

Space does not allow a full account of the DMM in this guide. See Crittenden and Landini (2011) for a detailed explanation. There are a range of validated tools for the assessment of attachment for different age groups. The adult attachment interview (AAI) is the most relevant for working with adults (George et al., 1996; Main et al., 2008; Steele & Steele, 2008).

Attachment and Adaptation: the A, B and C Patterns

Readers may be familiar with attachment terminology such as *avoidant/dismissing, secure/autonomous,* or *coercive/ambivalent* to describe attachment strategies. Rather than using these terms, this article instead offers the terminology A, B and C to describe the patterns. These are the original letter names given by Mary Ainsworth, with the advice of Bowlby (Crittenden & Claussen, 2000). The category labelled by some authors as *disorganised* is, in the DMM, conceptualised as a combination of A and C patterns and, potentially, a complex and multivalent attempt to cope with unresolved trauma and loss. Regarding the term 'disorganised attachment', this is a construct which has now undergone a definitive reworking by the originators of the term in response to 30 years of misunderstanding and misapplication of the concept (Main & Solomon, 1990; Granqvist et al., 2017).

Ainsworth, a USA-based psychologist who collaborated closely with John Bowlby, was the first to identify the A, B and C patterns in babies and infants (Crittenden & Ainsworth, 1989). She did this through her field work in Uganda and through her research using the 'strange situation procedure', the first empirical measure of attachment in humans. In the procedure, which involves a series of timed separations and reunions between mother and baby, Ainsworth observed three patterns of response:

- Some infants, when their mothers departed and returned, did not display distress (the A pattern).
- Some infants became upset when their mother left the room, and when she returned, they settled down when she comforted them (the B pattern).
- Some infants became highly distressed when their mother left the room and found it very difficult to settle when she returned, despite their mother's efforts to comfort them (the C pattern).

Ainsworth's study (Ainsworth et al., 1978) included observations of the parent-infant dyads over the course of the year prior to the strange situation procedure. This allowed the researchers to integrate their observations in the experimental situation with their observations of patterns of interaction between parent and infant during the previous year. This milestone research offered a rich seam of evidence supporting our understanding of how and why the A, B and C patterns are formed.

Integrating the work of Ainsworth, Bowlby and Crittenden, the following three sections explain the early life experiences that influence the development of the A, B and C strategies, and how the childhood strategies may further develop in adulthood. We begin with the B strategy, which balances thoughts and feelings.

Development of the 'B' Strategy

Two critical factors have a decisive influence on the development of a baby's self-protective strategies (that is, their attachment strategies): *predictability* and *attunement* of care.

- *Predictability* is important because it allows the baby to learn basic routines by making cause-and-effect links, for example, "If I cry, something happens that helps me to feel better."
- *Attunement* is important because an attuned response is an accurate response; it will tend to lessen the baby's distress and make it feel safe, comfortable, fed, rested, etc.

If, when a baby cries out, it receives a response that is both *predictable* and *attuned,* it will learn that its thoughts and feelings have equal self-protective value. The baby learns that information *inside its body* – physical feelings of hunger, tiredness, pain, hot and cold, boredom – have important self-protective value, because if the baby connects with its feelings and expresses them in the form of a cry, it will be helped to feel better by its predictably protective and responsive attachment figure.

Similarly, a baby learns that information *outside the body* – that is to say, their perception of their environment and cause-and-effect links such as 'if I cry, someone helps me feel better' - has equal self-protective value. Babies are capable from birth of learning such cause-and-effect links, through the processes of basic reinforcement of behavioural routines.

If the baby is growing up with attachment figures who offer predictable responses, and if these responses are attuned and responsive to the baby's needs, the baby will learn to value equally these two sources of information – the only two sources of information they have access to: the information inside and the information outside their body.

This will typically lead to the development of a 'B' attachment strategy in close relationships, that is, a strategy that *balances* thoughts (cognition) and feelings (affect). As this person approaches adulthood, they will be well prepared to give and receive care in an integrated way that satisfies both them and other people, including their children if they become a parent. This person is able to reflect

on and balance their own thoughts, feelings, abilities and goals with those of other people and adjust their behaviour accordingly, trusting that other people can respond to their expressed needs (Gerhardt, 2004).

Development of the 'A' Strategy

If, by contrast, the attachment figure's response to the baby's signals is *predictable* but *not attuned*, the baby is likely to develop a markedly different attachment strategy – the 'A' strategy.

When it cries, this baby may be consistently ignored, rebuffed, criticised or handled brusquely or ineptly. In severe cases of maltreatment, the baby may be screamed at or physically harmed. The common factor is not the severity of the discomforting response, but how predictable the response is.

In such circumstances, where the danger of being made to feel worse is predictable, the baby will soon learn to limit its tears, anger or clinginess, because such displays consistently increase its distress. It learns, 'when I feel bad, no one helps, and when I cry I feel worse'. As it grows, the child learns that thinking – in particular, thinking about cause and effect – is critical to survival. This child becomes *cognitively organised*, meaning it relies on its thoughts and distrusts/cuts off from its feelings. The child knows that thinking is what protects it, and to display fear, anger, sadness or the need for comfort puts it in danger or makes it feel worse.

The emphasis on cause and effect consequences may lead this child to develop ways of thinking and behaving that prioritise the outer world and discount inner experience. At the milder end of the continuum, which is normative in safe contexts, the A strategy may take the form of people-pleasing (being a 'good boy' or a 'good girl'), an emotional 'stiff upper lip,' or high academic and professional achievement.

Moving to the more concerning part of the continuum, a person developing an A strategy may also develop compulsive care-giving behaviours, putting the other person first. As an adult, if they have children and/or form relationships, they may become intolerant or abusive when faced with tears, clinginess, fear or anger in their own children or partner, because such displays have proved to have such negative consequences for them in the past.

Further still along the continuum, they may become highly controlling and even punishingly dominant as a way of regulating relationships to stay at a correct distance. Alternatively, they may become socially isolated, because human contact has proved to be so troubling and predictably damaging. In some circumstances, this can translate into superficial social promiscuity, where the person seems to have a wide circle of social contacts, but these contacts are kept superficial for reasons of self-protection. In some people, this social promiscuity can translate into sexual promiscuity, again following the pattern of achieving some level of human contact but at an emotional distance, where feelings are protected by the superficiality of the encounter.

People with extreme 'A' strategies may also experience psychotic episodes (for example, delusions or hallucinations that are either highly critical of them or which provide comfort and predictability) or sudden and uncharacteristic emotional outbursts, sometimes known as 'intrusions of "forbidden" negative affect'. The analogy might be that of a pressure cooker lid: the A strategy keeps the lid on powerful emotions, until the pressure is too great, and the lid explodes.

Sudden outbursts of emotion can include panic attacks (runaway fear); violence (explosive anger); convulsive and inconsolable sobbing; or sexual acting out (inappropriate, problematic or abusive comfort seeking).

In such circumstances, adults using such extreme 'A' strategies often find that their troubled thinking and problematic behaviour lead them into contact with mental health services, where they may be diagnosed with conditions such as psychotic illness, anxiety disorder or a personality disorder.

Development of the 'C' Strategy

The 'C' pattern develops when the infant experiences unpredictable and inconsistently attuned care from their attachment figure(s). The parent/carer sometimes responds sensitively, and sometimes not, sometimes too soon and sometimes too late. There are many reasons why a carer may be unpredictable, from mild distractibility, busyness with other tasks or looking after the baby's siblings, to – much more dangerously – serious substance misuse, domestic violence, unresolved trauma or mental illness.

The unpredictable parental response is very confusing for the baby, as it is not able to predict a causal link between crying and receiving care and attention. Its crying and other attachment displays sometimes means it receives the care and attention it needs, and sometimes not. But the baby can't predict when and how its attachment figure will respond. This baby is likely to learn that crying, when *exaggerated*, is more likely to get results, because the exaggerated display is difficult to ignore and is more likely to gain a parental response.

Consequently, the baby's tears become exaggerated, its anger becomes a temper tantrum, its sadness is inconsolable, its need for comfort is expressed in clinginess and displays of helplessness. As the child grows older, it may act out in any way that gains its unpredictable attachment figure's attention. This can include behaviour that is very harmful to the child or to other people. This could include extreme risk-taking in order to garner protection from their attachment figure. This behaviour confuses the attachment figure, who may be unaware that their inconsistency worsens the child's distressed and distressing behaviour.

When the C pattern is firmly established, typically by toddlerhood, both parent and child may together descend into a downward spiral of anguished struggle.

The child developing a C strategy learns that it is pointless to try to see the other person's point of view because other people's minds cannot be predicted. The child learns to stay firmly in its own perspective. It also learns that cause-and-effect contingencies have little value. This is because the child has grown up in an unpredictable environment, where cause and effect cannot be predicted in the normal way, without the added ingredient of heightened emotional expression.

Moreover, the child learns that to truly get its needs met and the attention it craves, it must not only gain the parent's attention, but must hold it. When the parent finally does respond, the child must continually change direction and create problem after problem, in order to keep the attachment figure engaged in an ongoing, everlasting sequence of unsolvable problems.

This is the essence of the C pattern, which is two-fold: first, *exaggerate* my genuine feelings of sadness, fear, anger or needing

comfort, and then, when I have my attachment figure's attention, *keep changing the problem*.

If an adult using a prominent C strategy comes to the attention of social services, they may have a wide range of presenting problems. In the mild part of the continuum, this person may appear overwhelmed by feelings of sadness, fear, helplessness or anger.

Where the C pattern is in a more extreme form, the person may feel either intimidating or menacing to the professional or, with their expression of vulnerability, invite rescue from the professional.

People using a C strategy may also have previously been given one or more diagnoses such as pathological jealousy or a personality disorder such as borderline, emotionally unstable or anti-social.

In the most extreme cases, where their emotions of anger and fear are running rampant and unchecked, people may develop delusional beliefs about themselves as being all-powerful (which may include thoughts about wanting to wreak angry revenge on people who have done them wrong) or relentlessly persecuted by powerful and deceptive people (paranoid and fear-driven beliefs such as 'they are all out to get me/there is danger everywhere').

Discussion

As mentioned, Crittenden (2016) pays particular attention to the way in which attachment strategies become more complex in line with the child's development and as they negotiate stage-specific tasks such as going to school, forming friendships, puberty, and so on. The DMM is an evolving, evidence-based model of attachment and adaptation that offers a step-change in our understanding of attachment and an alternative way of conceptualising psychological and emotional difficulties from a function-based (as opposed to a symptom-based), biopsychosocial perspective (Crittenden & Landini, 2011; Thompson & Raikes, 2003; Crittenden et al., 2021a, 2021c, Landa & Duschinsky, 2013b).

In describing the DMM, it is important to first point out that the DMM is distinctive in that it focuses on all the attachment strategies as potential *strengths*, not as disorders or dysfunctions (Baim & Morrison, 2023). To expand on this point, the DMM is a strengths-based, non-pathologising and non-labelling model, wholly suited to the emerging emphasis in the psychological treatment literature on strength, growth, flexibility, adaptation, positive life goals, prosocial living, positive psychology, social capital, post-traumatic growth, personal development and adaptation, and co-production of assessment and therapy between therapist and client. This contrasts with other approaches that focus on disorder, dysfunction, destructiveness, weakness, illness, labels, risk, problematic thinking, and symptom-based diagnoses. As such, the DMM is a theory that is very much a part of the broad paradigm shift taking place within the psychological and psychiatric research and treatment towards an emphasis on biopsychosocial functions (including systemic/contextual factors), rather than diagnoses based on symptoms and seeing individuals in isolation (Dallos, 2006; Dallos & Vetere, 2021; Engel, 1979; Johnstone & Boyle, 2018; Maté, 2019; McGoldrick et al., 1999 ;van der Kolk, 1996; Wallin, 2007). The DMM also fits well with the increasing adoption of trauma-informed approaches within health, education, criminal justice and social care settings.

The DMM offers a model of attachment across the lifespan that addresses the developmental processes and clinical applications described by Bowlby (1971) and Ainsworth (1978). The DMM began in Ainsworth's laboratory with two samples of maltreating families with infants and young children (Ainsworth et al, 1978; Crittenden & Ainsworth, 1989) and expanded to a life-span theory of adaptation and treatment of maladaptation (Crittenden, 2016; Crittenden et al., 2014; Landini et al., 2015). As such, the DMM is highly relevant to professionals who work with families. In the DMM, the patterns of attachment provide a description of interpersonal behaviour as a well as a system for diagnosing psychopathology that is focused on the *function* of behaviour rather than the surface appearance of the behaviour (the symptom). It is unlike other theories of psychopathology in that its perspective began with infancy studies and progressed forward developmentally, rather than beginning in adult disorder and attempting to reconstruct the developmental precursors of disorder (Crittenden & Baim, 2017). The DMM represents a comprehensive integration of existing ideas and research findings into interventions that work. One of the standout features of the DMM is how open it is to revision and change suggested by different critical perspectives and emerging empirical research.

It will be useful for the reader to understand that there are two main branches of attachment theory, both derived from primary research done with Mary Ainsworth, the creator of the Strange Situation Procedure, the first scientifically researched empirical assessment of attachment. One branch of attachment theory has been termed the 'ABC + D' model, or the Berkeley model, (Landa & Duschinsky, 2013a, 2013b; Duschinsky et al., 2021) which includes the concept of 'disorganisation' (D) – a construct which has, as mentioned earlier, recently undergone a definitive reworking by the originators of the term (Granqvist et al., 2017). The DMM is the other major branch of attachment theory and is the model we use in this book. Readers may be familiar with attachment terminology such as *dismissing attachment style, balanced/secure,* and *preoccupied/ ambivalent*. The DMM instead uses the letters *A, B,* and *C* to stand for the attachment patterns. As described earlier, these are the original letter names suggested by Bowlby to offer a neutral, non-stigmatising label to the three patterns (Claussen et al., 2002).

Based on the DMM's rigorous empirical support and scientific validity (Crittenden, Spieker and Farnfield, 2021c), it is likely to play an expanding role in the scientific understanding of human development and psychopathology. The DMM is taught internationally and has been validated in a wide range of studies and described in more than 500 publications (International Association for the Study of Attachment-IASA, 2024). The research continues in more than 20 countries with many different populations. Notably, the DMM is a core theoretical model (along with compassion-focused and trauma-informed approaches) referenced in the recent *Power, Threat and Meaning* (PTM) framework published by the British Psychological Society (Johnstone & Boyle, 2018; Boyle & Johnstone, 2020). This landmark publication describes a paradigm-shifting approach which has far-reaching implications for the whole field of psychological assessment, formulation, and intervention. The DMM integrates ideas from evolutionary biology, psychoanalytical theory, cognitive neuroscience, social ecology, Gestalt Theory, person-centred therapy, and many other forms of psychotherapy. Systemic family therapy is one of the more prominent modalities integrated with the DMM.

In the DMM, attachment is conceptualised as a bio-psycho-social

theory about how we organise to protect ourselves from danger. Put another way, in DMM terms, attachment is an *interpersonal* strategy to respond to threat or danger which reflects an *intrapersonal* strategy for processing information. Notice from this DMM definition of attachment how important the interpersonal aspect of attachment is. Using this definition of attachment, we see that our attachment strategies don't just sit within us; instead, they emerge within the interpersonal context. What this means is that a person's attachment strategies are contextual; the strategy used may vary depending on the context and the person. This is a crucial distinction, because other attachment theorists will tend to ascribe the strategy to the person, rather than to the person-in-context.

Furthermore, in contrast to earlier assumptions that our attachment strategies are fixed or 'set in stone' by age three or four, empirical research in the past forty years points to the notion of neuroplasticity and that our brains can make highly significant changes and learn new patterns across the lifespan (Barrett, 2017; Cozolino, 2002, Eagleman, 2020). Applying the notion of neuroplasticity to the concept of attachment, research in psychotherapy outcome studies gives us confidence and hope that attachment strategies can be adapted, changed, and made more flexible across the lifespan.

It is important to remember that the A and C patterns are, in their milder forms, normative in situations of safety. However, among clinical and especially referred populations, it is most common to see the concerning and endangering aspects of type A and C strategies. In other words, the extreme forms of the A and C strategies are also normative, but in contexts in which there is danger of a *predictable* (A strategy) or *unpredictable* (C strategy) type. The way in which the DMM describes the increased complexity of the Type A and C strategies amongst populations exposed to greater risks and increased danger, as described above, is particularly helpful. By depicting these strategies along a continuum from normative to endangering, the DMM gets beyond the secure versus insecure debate and focuses to a much greater degree on understanding strategies as adaptive to contexts.

The context is important when we consider what is 'normative' (i.e. 'normal' or typical) in each cultural, social, or political context. 'Normal' strategies in a relatively safe, open society will be very different from 'normal' strategies during dictatorship, war, civil crisis, occupation by foreign powers, or other severe and chronic dangers faced by large populations. Translated to the home environment, we can see that 'normal' behaviour may take on a very wide range of presentations, depending on the types of danger the family members currently face or have faced in the past. One important implication of this approach is how we conceptualise so-called 'personality disorders,' the definition of which partly depends on what is considered 'normal' behaviour in each society. We need to work with an understanding of how many diagnoses are dependent on cultural and social definitions of what 'abnormal' thinking and behaviour is. This becomes even more crucial when one is working with immigrant populations who may have faced grave dangers in their countries of origin, and who may struggle to adapt to new (and hopefully safer) cultural contexts after arrival in the new country. If they are still adapted to the old dangers, when the dangers are no longer present, their strategies can be misinterpreted and misunderstood unless the professionals include a thorough assessment of how the person's strategies once served a useful function in their previous cultural context.

As we move to the more extreme strategies, the likelihood increases that at some point in the person's life, they will need help from professional services because they are likely to struggle with unresolved trauma, loss, or depression, or to pose a danger to themselves or other people. At the extremes of adaptation, it is likely that the person will need intensive support and possibly institutional help or containment for short or long periods of time. This is not always the case, because much depends on the person's access to social supports, helpful family members, friendship networks, and other resources (including inner resources). It also depends on how extreme their strategy is, how inflexibly it is used, and whether the person can use other strategies when needed. Given the large numbers of factors, DMM assessments are highly individualised; they do not use broad diagnostic labels such as 'borderline,' 'OCD,' or 'PTSD,' but instead offer individualised classifications, reflective of each person's strategies in their developmental context.

Another advantage of the DMM is its emphasis on adaptation and change, which reflects Bowlby's (1971 and 1995) commitment to a systemic view of relationships and the importance of context in understanding behaviour. The dynamic nature of the DMM also offers a hopeful message about the potential for change, particularly through containing and attuned relationships. One way of thinking about goals of psychological treatment in relation to the DMM would be to say that progress would be represented by 're-organising' the mind in the direction of the integrated 'B' pattern (even if one moves towards 'B' this would be progress, even if never fully organising a 'B' strategy).

Finally, it should be remembered that these more severe patterns may be considered strategic and adaptive in situations of danger, whether this arises from inter-personal factors, or national crisis such as war, forced migration, famine, disease, or natural disaster. This reflects Crittenden's (2016) central idea that attachment strategies are self-protective responses to a dangerous environment. Thus, all attachment behaviour can be considered purposeful or functional to the individual at the time it is first displayed, even if the same behaviour is later problematic or harmful to others (i.e. when it becomes maladaptive).

Typical Patterns Seen in Maltreated Children and Maltreating Parents

The full version of the DMM includes several additional features which give more complete detail about the sub-classifications of the A, B and C strategies and outlines in greater detail the ways in which information is transformed in the concerning and endangering parts of the model. Because maltreated children are essentially never securely attached and the use of these strategies increases maltreated children's safety and comfort, the DMM focuses more on 'adaptation' rather than security, as compared to other models of attachment.

What is particularly important to note about the DMM is that it allows for a highly flexible 'mixing' among the strategies, recognising that people and their strategies are complex and that many people will have blends of A and C strategies, some in a more integrated way than others. Indeed, the 'B' pattern itself is a mix of A and C strategies, but in an integrated way. The DMM model also incorporates an attachment-based conceptualisation of psychopathy (Baim, 2020).

Broadly speaking, there is a correlation between the age when the strategy was organised and the harm experienced in childhood.

Examples of age-salient dangers are separation/abandonment in early childhood; rejection, teasing, mocking, and bullying in middle childhood; and deception, betrayal, romantic rejection, and premature home leaving in adolescence. Endangered children are at risk for psychological problems (de Zulueta, 1993; Duschinsky & White, 2020; Gerhardt, 2004; Hertzman, 2013; Keyes et al., 2012; McLaughlin et al., 2012; Perry, 2008; Read et al., 2004). The most severe disturbances (e.g., eating disorders, personality disorders, the psychoses, and violent or sexual forms of criminality) typically develop in the transition to adulthood. These problems may require a series of age-salient threats to coalesce (Cicchetti & Valentino, 2015; Crittenden, 2016; Crittenden & Baim, 2017; Landini et al., 2015). By early adulthood, information can be utterly transformed: true and false, pleasure and pain, and safety and danger can become reversed in the person's mind. At such extremes, care or affection can be perceived as treacherous; this causes profound problems of trust in relationships — including therapeutic relationships. And in personal relationships, the confusion of pleasure and pain, safety and danger, true and false, can lead to behaviour in relationships and sexual encounters that is dangerous to the self and / or others.

Why the focus on danger rather than safety? For the answer, we can go directly back to the research and writings of John Bowlby, who combined his work as a psychiatrist, psychologist and psychoanalytically trained psychotherapist with studies of ethology and evolutionary theory (Duschinsky & White, 2020; Bowlby, 1971, 1980, 1995, 2000). Bowlby observed that in the broad scope of human evolution, danger has been the norm, and human beings have evolved to adapt to predictable and unpredictable dangers of a mild or life-threatening sort. (It is possible, for example, that the C strategy has historically been the most common strategy used by humans over evolutionary history, because it is the best strategy for dealing with unpredictable dangers — including unpredictable access to basic resources and unpredictable threats from competing groups.) Later in life, these functional and context-specific adaptations, when used out of their original context, can lead to highly destructive or self-defeating behaviour — indeed, behaviours with labels such as *dissociation, personality disorder, psychosis, paranoia, anxiety* and scores of other mental health diagnoses that are based on symptoms. Yet in their original form and context, these behaviours may well have been life preserving and safety promoting strategies. Therefore, they should be seen in their original context as *strengths, not deficits,* because they have served a self-protective function. This has many practical implications for how we think about and offer interventions.

As children mature, their attachment strategies can increase in complexity, since normal neurobiological development enables processing of sensory information at increasingly sophisticated levels. Put simply, maturity offers us the opportunity to think with increasing complexity as we grow older. The term 'Dynamic-Maturational Model of Attachment and Adaptation' was chosen to reflect the potential of adaptive strategies to change within individuals across their lifespan (Crittenden & Landini, 2011). These strategies are seen as existing on a continuum of attachment security and are viewed as adaptive when first developed by a child. A child who anxiously hides, dissociates, becomes a 'people pleaser', cries, fights, distracts, becomes hypervigilant, rapidly changes focus or complains may be using an adaptive response to survive in some families and communities. Those same behaviours, used later in life, may lead to very different outcomes — including behaviour that is neglectful or abusive to others. This is crucial to our understanding of psychological disturbance: the very same strategy that is adaptive in childhood or adolescence may be *maladaptive* later in life.

This guide does not have sufficient space for us to provide full coverage of Crittenden's elegant model, particularly the extreme patterns at the bottom of the circle. Readers who wish to learn more about the DMM are encouraged to read Crittenden (2016) or Crittenden and Landini (2011) or Landini et al. (2015), or visit IASA-DMM.org or familyrelationsinstitute.org.

Disorganisation

Thus far, we have not mentioned the impact of unresolved trauma and loss on attachment strategies. However, it will be recalled that in addition to the three basic attachment strategies (A, B and C), the Strange Situation Procedure identified a group of children who were 'unclassifiable' and who were later reclassified by Main and Solomon (1990) as exhibiting a 'disorganised' response. This occurs when there is no discernible pattern to the person's self-protective strategy and may emerge when a child's attachment figure is frightened, frightening, traumatised, or disorganised themselves (or some combination of all these). In effect, they are both *unpredictable* and *the cause of the distress*. The child faces an unsolvable dilemma in trying to gain comfort and safety from the very person who is causing their distress. The result is wildly fluctuating behaviours, including violent or provocative outbursts or incongruent actions that try simultaneously to approach and avoid the attachment figure (for example, sitting on the carer's knee while turning away and grimacing, or physically lashing out, which is both pushing away and making physical contact). Hence the child is subject to deeply conflicted impulses, resulting in their mental processes and external behaviour becoming *disorganised.* Children who have been exposed to such experiences are at particular risk of emotional and behavioural problems. Indeed, Howe (2005) points out that the key distinction is not between secure ('B') and insecure ('A' and 'C') attachments, but rather between *organised* (i.e. the A, B and C patterns) and *disorganised* attachment states.

It is important to note that there is wide variation in the attachment field about how broad a category the 'disorganised' designation should be (Landa & Duschinsky, 2013b). Some authors find richly strategic patterns among maltreated populations (Landini et al., 2015). For other authors, as many as 80 per cent of clinical populations are classified as having a disorganised strategy. In Crittenden's Dynamic-Maturational Model of attachment and adaptation, 'disorganisation' is a far smaller category and is conceptualised as only one of several ways that the mind copes with unresolved trauma and loss. (Other ways that the mind may find to cope with unresolved trauma and loss include blocking, dismissing, displacing, or becoming pre-occupied with the event.)

Summary

The DMM expands Ainsworth's model of individual differences in middle class, non-maltreating families with a wider array of strategies used in maltreating families and families with mental illness. Seen in the context of the family system, children's

attachment strategies are understood as the child's best solution for obtaining safety and comfort from the caregivers on whom their lives depend. The DMM offers an alternative to symptom-based diagnoses of psychopathology by focusing instead on the function of the 'symptom' behaviour (Crittenden & Ainsworth, 1989, p. 442-463; Crittenden & Baim, 2017; Fonagy, 2001; Wallin, 2007).

Crittenden's expansion of Ainsworth's work includes more complex strategies used by older children and adults. These comprise compulsive Type A strategies (A3-8), coercive Type C strategies (C3-8) and A/C combinations. These strategies reflect commonly recognised forms of maladaptive behaviour but differ from symptom-based diagnoses in that they are seen as a functional attempt to reduce danger and increase comfort and safety. They differ from the ABC+D model (where D denotes 'disorganisation') in finding both organisation and adaptive function in disturbed behaviour. When the function better fits the past context in which the behaviour was learned than the current context, the behaviour can be maladaptive and even dangerous.

It is worth remembering, however, that it is not the danger itself that creates psychological and interpersonal problems. Problems arise due to the short-cuts in information processing that must be made when the danger is more than the individual can cope with and when such danger must be faced without protection or comfort from a trusted caregiver. Complicating the danger even more is the fact that many parents who maltreat their children have themselves experienced unprotected and uncomforted danger and have entered adulthood and parenthood with the transformations of information and strategies associated with endangerment (de Zulueta, 1993; Milaniak & Widom, 2015; Rothschild, 2000).

The Dynamic-Maturational Model (DMM) of attachment and adaptation offers a comprehensive model that helps us understand even the most extreme or endangering forms of human behaviour and mental processing as being *functional* and *comprehensible*. The DMM is a powerful way of moving beyond the labels of mental disorder, illness, disease, and dysfunction, to focus instead on the adaptive function of human mental processes within differing contexts.

See Crittenden (2016) or Landini et al. (2015) for fuller coverage of the DMM and the research supporting its clinical applications (Crittenden et al., 2021a, 2021c; Landa & Duschinsky, 2013a, 2013b, Pocock, 2010).

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