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Clinical Applications of the Dynamic-Maturational Model of Attachment and Adaptation: Assessment, Formulation and Principles of Care

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ABSTRACT

Earlier in this journal issue, I offered an introduction to Dr Patricia M. Crittenden's Dynamic-Maturational Model (DMM) of Attachment and Adaptation. The DMM is a bio-psycho-social model, informed by neurodevelopmental research, and as such it offers a developmental understanding of the wide range of adaptations used by people who are endangered or endangering to others, or who may need psychological or social care support for a wide variety of reasons. The DMM is a strengths-based, non-labelling and non-pathologising model which conceptualises adaptations to danger as self-protective strategies that promote survival in their original context, but which may later lead to problematic, dangerous or self-defeating behaviour. This article focuses on the clinical applications of the DMM, which includes DMM-informed principles of assessment, formulation and care.

Aplicaciones Clínicas del Modelo Dinámico-Maduracional de Apego y Adaptación: Evaluación, Formulación y Principios de Atención

RESUMEN

En un número anterior de esta revista, ofrecí una introducción al Modelo dinámico-madurativo (DMM) de apego y adaptación de la Dra. Patricia M. Crittenden. El DMM es un modelo biopsicosocial, basado en la investigación del desarrollo neurológico, y como tal ofrece una comprensión del desarrollo de la amplia gama de adaptaciones utilizadas por las personas que están en peligro o que ponen en peligro a otros, o que pueden necesitar apoyo psicológico o social por una amplia variedad de razones. El DMM es un modelo basado en fortalezas, no etiquetado y no patologizante que conceptualiza las adaptaciones al peligro como estrategias de autoprotección que promueven la supervivencia en su contexto original, pero que más tarde pueden conducir a un comportamiento problemático, peligroso o autodestructivo. Este artículo se centra en las aplicaciones clínicas del DMM, que incluye principios de evaluación, formulación y atención basados en el DMM.

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Attachment-Informed Assessment, Formulation, and Treatment Planning

This section outlines a series of topics and activities that practitioners can use with individual adults, with couples, and with families, to carry out cost-effective assessments informed by the Dynamic-Maturational Model (DMM) of attachment and adaptation (Crittenden, 2016). The method described is an adapted version of a type of assessment called a 'screening formulation,' as distinct from the more detailed and resource-intensive form of assessment known as a 'family functional formulation.' What distinguishes an attachment-based formulation from standard diagnostic procedures is that in an attachment-based formulation, the various assessments are brought together to create – in a collaborative, co-produced dialogue between professionals and the person / people in focus - a functional formulation of the person's (or the couple's, or the family's) difficulties. The idea is to condense and categorize the most essential and relevant information about the family, couple or individual and communicate it clearly to the person and to other professionals involved with them. The advantage of using an attachment-based formulation is that it can be done much more economically and efficiently and without specially trained DMM-informed coders, yet it can still provide a function-based formulation. In practice, the attachment-based formulation can be done with individuals, couples, and families where the problems are relatively straightforward to understand. Where there is great complexity, or where there are multiple problems, or where the individual, couple or family have been subject to many prior treatments and services, it may be justified to offer the full range of DMM assessments and the more rigorous Family Functional Formulation (or, for individuals, an objective, blind-coded report by a qualified AAI coder) – where this is available.

Focus on Personal History and Family / Social / Cultural Identity and Belonging

In learning about the developmental history of the person we are assessing (or each person in a couple or family), we gather important biographical information about important relationships and life events. This should be information that is relevant to the formation of the person's identity, beliefs, values, self-protective strategies, and sense of who they are as a person. This part of the assessment process can be accomplished using any of a wide variety of history-taking protocols. This might include, for example, creating a family tree / genogram, or mapping out the social network around the individual or everyone in the family or couple. In doing the social network mapping, you can explore what interpersonal connections the person has. What is the quality of these connections? How do they achieve a sense of belonging? What is their sense of who they are and where they fit into society, i.e. their sense of identity, and their sense of where they belong?

Strengths

What are the person's strengths? These can be divided into personal strengths, interpersonal strengths, transpersonal strengths, and any other strengths they can identify. It can help to identify not just the strengths, but where and why and how those strengths were developed, where they have been useful in the past, and where and how they continue to be useful today.

Themes of Significance, Growth and Contribution (Giving Back)

Extending the theme of strengths, you can explore how the person has tried to achieve a sense of being significant, effective, or powerful. Can they provide examples of when they have accomplished a goal, trained for a job, improved a skill, or been kind or supportive to someone? What stories of strength can the person recall?

Using this approach, you can also help the person identify what is most important to them, for example, having a relationship, having children / being a parent, having work, doing meaningful things, having friends, being healthy, playing music, or cooking, or creating art. Then the client can be helped to develop a plan for meeting those needs and aspirations in positive ways. What are their hopes and aspirations? Where might there be possibilities for growth, internally and interpersonally, in any aspect of life? Where might there be opportunities for them to contribute to society, for example by volunteering, making reparations, or assisting in support groups for people with similar experiences? How has the person tried to achieve a sense of being significant or powerful?

Developmental History Related to Danger and Safety

Closely related to history taking is the specific focus on the person's history of encountering danger, and how they tried – successfully or otherwise – to cope with danger at the time and how the experience of the danger affected them in the short, medium and long term. One useful method of helping a person to think about and reflect on these dangers is to create with them a timeline of significant positive, negative, and neutral events in their life, from birth to the present day. The timeline should include the major dangers that the person has faced, both in early life and more recently. Dangers might include accidents, abuse, neglect, verbal abuse, parental separation, conflict, divorce, or death. Dangers can include having a mentally ill parent, substance misuse in the family, criminal activity, having a family member in jail, being separated or removed from the home as a child, being rejected by peers, suffering economic hardship, racism, other forms of oppression, natural disaster, political unrest, war, and many other forms of danger. Where a danger is identified, the person should be encouraged to consider whether there was anyone around at the time to help them, to comfort them, to protect them, and / or to hear and validate their feelings in response to the dangerous events. Where people have encountered dangers that were beyond their zone of proximal development at the time, such events are far more likely to manifest as unresolved traumas or losses if there was no attachment figure present to help them, comfort them, protect them and validate their feelings.

The assessment should include understanding the client's experiences and memories of danger, protection and comfort (or lack of protection and comfort) across their lifespan. This should include consideration of ongoing psychological trauma and unresolved loss (Reupert et al., 2015; Schützenberger, 1998). When considering a person's experience of danger in the past, it will be useful to reference the *danger scale* (adapted from Crittenden & Landini, 2011; Crittenden, 2021):

1 – 2 Developmentally normal, expected dangers, from which the child was adequately protected and comforted. *Examples:* being hungry or tired (infancy); falling over (toddlerhood), skinned knees, competition with a sibling (preschool); seeing parents argue, being teased, being rejected by peers (school-age); being rejected by a girlfriend / boyfriend, experimenting with drugs / alcohol, arguing with parents (adolescence).

3 – 4 Developmentally normative dangers for which one was protected, but not comforted OR developmentally inappropriate dangers from which one was *protected and comforted*. *Examples:* being bullied (school-age and adolescence), serious accidents/illness not requiring hospitalisation, physical punishment of young child for dangerous behaviour, distant family death, victim of crime.

5 – 6 Developmentally inappropriate dangers from which one was *neither protected nor comforted*. *Examples:* serious accident or illness requiring hospitalisation, bullying, chronic rejection / exclusion from school, close family (non-parent) death, victim of crime, mentally ill parent, physical / sexual abuse (non-familial) foster care or siblings in foster care, substance using parent, war.

7 – 8 Parentally inflicted dangers (no comfort, no protection) or self-inflicted dangers. *Examples:* physical, emotional or sexual abuse/neglect within family, being sent away to live away from parents, triangulated deception, being deceived, child in care, running away, self-harm, overdosing

9 Events that would be threatening to adults as well. *Examples:* death of spouse / child, death of parent - especially in childhood, repeated unexplained hospitalisation of an attachment figure.

10 Ongoing serious endangerments in the present. *Examples:* Partner abuse, neighbourhood violence involving self or family, criminality, dangerous psychosis, war, civil unrest, natural disaster.

When we take into account the danger scale, this brings needed context to significant life events such as those found in the Adverse Childhood Experiences (ACE) study of childhood trauma (Felitti, 2002). For an important critical perspective on the uses and limitations of the ACE questionnaire, see Eaton (2019).

It is important to be aware of when and where the person / family may feel there is danger intruding on their life currently, and in the present moment of the session. This may be implicit or explicit danger. One form of danger, for example, would be when the client is aware that making certain kinds of disclosures to you will result in sanctions or what they perceive as punishment. Or they may be concerned about current peer influences or threats which are currently active – for example, a threat from peers, from extended family members, or from the police, courts, or social services. This will keep them on alert, and we should be realistic about our expectations of clients in these circumstances. Another type of danger the client may perceive is the pain and fear associated with recalling life events, relationships, traumas, and losses that are unresolved. Such topics will demand sensitivity, attunement and clear boundaries and contracting about what the purpose is of discussing these topics.

Relationships and Sexuality

Assessment and intervention should address how the person / family members function in relationships, particularly close relationships (including, where relevant, sexual relationships). What is the intrapersonal and inter-personal function of their sexual behaviour? Is the sexual behaviour, for example, a way of coping with feeling afraid, rejected, unloved and needing comfort? Is the person seeking comfort in ways that are problematic, risky or abusive? This information can be learned as supplemental to the history taking activities described above. Reflecting on the person's functioning in relationships – including sexual relationships – how does the person's history correspond with their functioning in relationships? In other words, can you make sense of how and why they function in relationships as they do, based on what you have learned about their past? If not, this will often signal that significant therapeutic work is needed. This aspect of the assessment should also include how the person / family functions interpersonally with you.

Information Processing and Correcting for Bias: The Client and the Worker

Assessment should also consider how the person processes information – that is to say, how the person balances and integrates their perceptions, thoughts, and feelings. Does the person *omit* crucial information from their awareness, such as their own or other people's roles in an event? Or do they omit feelings and focus only on facts – or vice versa? Does the person make significant *errors*, such as misattributing cause and effect, or blaming the wrong person for an event? Do they *distort* information, for example by minimising or exaggerating feelings or responsibility? Do they *deny* information that they are fully or partially aware of? Do they deny factual information, or deny their own feelings and perspective? Do they *falsify* information about events, emotions or their actions or intentions, and treat this information as true? Are they deceiving themselves and/or you? Do they attempt to get you to collude with or believe the falsified version of events? How aware is the person of their self-deception or their deception of you? (Deception can be fully conscious and intentional, wholly unconscious, or somewhere in between).

When we take an information processing approach in thinking about our clients, we should also consider how we hold our clients in mind. What are our own dispositional representations about the client and the family as a whole? For example, what conscious or unconscious biases may be influencing us? Are we making assumptions about the client or the family? What stereotypes or culturally 'scripted' roles might be getting played out in our interactions with the client or the family? Are we aware of patterns of response that we tend to have when facing individuals or families with these problems or with these backgrounds? How might professional dogma, professional assumptions, societal or cultural stereotypes be operating? For example, there may be professional dogma that assumes one person in the family is responsible, or that a person's actions are fully intentional, that one person in the family has 'groomed' another, or that a member of the family does not take responsibility or show any self-awareness because they do not verbally admit to their problematic, concerning, or harmful behaviour. It is important to test out any assumptions which can influence our professional judgment. Similarly, it is crucial to test out any assumptions that one person in the family is the villain or is somehow 'ill' or psychologically unwell in isolation, i.e., we need to understand how the person's troubles may be influenced by a troubled or unattuned family system. This is not about blaming or shaming anyone in the family. It is about trying to understand the system

as a whole and each person in the system. Thorough assessments allow for this kind of small scale and big picture perspective, so that professionals can better achieve an accurate understanding of the family and each person in the family.
Hirarchy of Needs: giving priority to the most crucial areas first. In our assessments, it is crucial to also consider people's basic needs. Therefore, it is useful to consider Maslow's (1943, 1954) well-known hierarchy of needs, including basic physiological needs to stay alive and healthy, such as food, water, shelter, basic sanitation, access to health care, and physical safety for the self and family members. Beyond these basic needs, Maslow's hierarchy of needs includes factors such as the need for belonging, for love and affection, for predictability in relationships, for self-esteem and for opportunities for creative expression and pursuing meaningful life goals (including employment).

Levels of Family Functioning

In cases where you are assessing an adult where there are concerns about their treatment of their child or children, or when making decisions about allocating services to the family, professionals may find it useful to consider the following levels of family functioning adapted from Crittenden (1992, 2016):

- Independent and Adequate. The family can adequately meet the needs of the children. The family can also face problems and crises, and deal with them adequately.
- Vulnerable to Crisis. The family are normally functioning well or adequately, but they need short term (e.g. up to a year) assistance with an unusual problem such as divorce, chronic illness, family death, serious crime, the birth of a disabled child or the entry of a disabled child into school.
- Restorable. The family has many problems that demand a range of new skills and possibly therapy or other types of intervention or service. After one to four years of support and intervention, it is expected that the family will function adequately and with no or minimal services.
- Supportable. The family will need long-term functional support to help meet the physical, emotional, educational, and other basic needs of the children. This is likely to continue until the children are grown. Examples of families that are in the supportable range include families where the parent / main carer has an intellectual disability or where the parent / main carer is drug or alcohol dependent.
- Not Supportable with Services Currently Available. The family has a very high degree of need and there are currently no services available in the area sufficient to enable these families to meet the basic needs of the children and keep the children safe. Removal of the children may be the only option remaining.

Gradient of Interventions

Professionals can use as a guideline the following gradient of interventions (Crittenden, 2016, p. 270). This gradient will allow professionals and agencies to set the intervention at a level best suited to the individual and / or the family (e.g. parent-child dyad; sibling dyad; couple dyad):

- Basic needs and support for the parent / carer and family. The parent / carer needs basic support regarding housing, physical safety of the family, money, food and water, and / or other basic needs as a matter of priority, before other needs are addressed. Ref: Maslow's Hierarchy of Needs (Maslow, 1943, 1954).
- Parent education. The parent / carer can integrate but needs new information. Parenting skills programmes may be suitable at this level.
- Short-term counselling. The parent / carer can integrate and has appropriate information about parenting. However, they need short-term counselling to help them reflect on their parenting and to consider other perspectives and possibilities.
- Parent-child intervention. The parent / carer can describe problems in their interactions with their child, including their own contribution. However, the parent has difficulty spotting discrepant information and cannot integrate where they do see discrepant information. At this level, carefully guided parent-child dyadic interventions may be beneficial.
- Adult psychotherapy *(personal, not focused on parenting)*. The parent / carer is not yet ready for parenting interventions at levels 2, 3 and 4. They are not aware of why they do what they do in relation to their child, and their responses are maladaptive, even dangerous. The parent needs psychotherapy to help them understand their 'triggers,' to come to terms with past dangers, and to recognise discrepancies and make meaning from them. The parent / carer will also benefit from having an experience of being empathically understood as a bridge to them responding more empathically to their children.
- Long-term support. Long-term functional support to help meet the physical, emotional, educational, and other basic needs of the children and the family. This is similar to item 4 under the previous section addressing levels of family functioning.

Critical Cause of Danger

This is the danger around which the person or family has adapted a self-protective strategy. Focus on the critical cause of danger encourages us to narrow the definition of 'the problem' so that we do not try to focus on everything at the same time – just the most important things for the person or family currently. For example, it may be about surviving abuse or neglect, or surviving abandonment, separation, or chronic emotional abuse. The danger can also be a current danger, such as relationship violence, drug abuse, or being investigated by social services about child protection concerns for your children. The critical cause of danger is often hidden, and part of the reason for this is that the dangers often lie far in the past, and the person may have little or no understanding of the reasons why they originally adapted the coping strategy, and whether or why they still use the strategy in situations where it no longer applies.

Critical Focus for Change

The idea behind addressing the critical focus of change is to direct treatment where it is most likely to have the maximum effect, and to have cascading and beneficial effects for the individual or within the family (Crittenden, 2016). Attachment and the quality of inter-personal relationships is often a critical cause of change. In addition,

understanding and reducing the danger is often a critical cause of change. When the danger is reduced, the person's strategy can change.

Developing a Treatment Plan Based on a Function-Focused, Biopsychosocial Approach

Using the information from the assessments in the previous section, the clinician can bring all the areas together to formulate a treatment plan based on a biopsychosocial understanding of the person's / couple's / family's difficulties. When we describe an integrated, biopsychosocial approach, we are describing a way of assessing, understanding, and offering interventions that consider people in their context (Engel, 1979). This can help professionals and services to work more efficiently and effectively at the level appropriate to the individual and the family concerned.

Discussion

Based on this approach to assessment and formulation, a treatment plan can build on strengths and address needs, while also being aware of risks. It should specify the number of sessions the person / family should do, which approaches and exercises should be chosen, a rationale for the sequencing of treatments, which adaptations / variations are likely to prove most fruitful, and what the aims are. The treatment plan should always allow for the possibility of modifying the plan as work proceeds. Thorough assessment should result in a comprehensive functional formulation of the person's / family's troubles that looks beyond symptoms and into their underlying function. What purpose did this strategy serve when it was first used? What purpose does it serve now? Can other strategies work better?

Principles of Practice for Attachment-Based, Integrative Treatment for Adults and Families

The following ideas capture the essence of integrative treatment that is attachment-based and informed by the Dynamic-Maturational Model (DMM). The following section draws on material from Crittenden and Baim (2017), Crittenden and Landini (2011), Crittenden et al. (2014, 2021a) and Landini et al. (2015).

The Central Importance of the Therapeutic Relationship

The basic premise of the attachment-based, integrative approach is that treatment is the process of using an informed, regulated relationship to promote the person's ability to establish and maintain adaptive relationships. Establishing a therapeutic relationship is crucial because the relationship with the professional can function to correct the experience of earlier, mis-attuned relationships. In effective therapy of many types, the therapist becomes a transitional attachment figure for the client, assuming crucial functions of a nurturing parent. This can help the client to develop a felt sense of security and trust in relationships, to learn to trust and regulate their own emotions, and to develop healthy intimacy. To do this, it is crucial that the professional appreciate the person as they are, particularly regarding the aspects of their experience that they may be unaware of.

Treat People, not Diagnoses

A key principle underlying the integrative, attachment-informed approach is that we treat *people*, not their 'disorder' or diagnosis. This is because diagnoses tend to be based on clusters of symptoms or behaviours, and if we focus on treating a symptom, or a cluster of symptoms, we are likely to miss the chance to understand the meaning and function of the symptoms. Eliminating or reducing symptoms may of course serve immediate needs, yet the challenge remains to help the person and the family to make lasting changes. In broad terms, integrative, attachment-informed treatment is a relational encounter where we help the client to: 1) understand how their past influences their present; 2) become more conscious of their self-protective strategies; and 3) function in more integrated ways, both internally and inter-personally.

In offering integrative treatment, rather than treating disorders, the priority is to offer treatment by using *principles* rather than packages, protocols or programmes (see Carey et al. (2015) for comprehensive coverage of principles-based counselling and psychotherapy). To put this another way, the question is not, 'What is the most effective treatment for Borderline / Depression/ PND / Psychosis/ OCD / ADHD / PTSD / PD / Anxiety / Addiction / Phobia / Sexual offending (or any symptom-based or behaviour-based diagnosis or criminal category)?' The question is instead, 'What (varied) treatment approaches and techniques might be effective in helping this person, and this family, at this time, in this context, and in what sequence, in what amount, through what process, with which person / people, and with what in place around the process to help support the individual and the family in their process of change (especially when there are ruptures / lapses)?'

Using these questions, we can responsively adapt to individuals and families. Rather than fitting people and families into packages and programmes, and thereby giving people information they may be unready to use, we can instead guide people to use information more adaptively and within their zone of proximal development.

Understanding Contradictory Thought Processes and how They can Affect Parenting

Difficulties can develop when a person has contradictory thought processes and lacks the skill, insight, self-reflection, and other integrative processes for selecting the response that best fits the current situation. In family dynamics, danger often arises when there is, for one or more individuals in the family, an irresolvable conflict, tension or contradiction between their needs to protect the self, their partner and their progeny (Crittenden et al., 2021a). This implies that treatment would need to focus on resolution of or reframing this conflict, tension or contradiction. An example of a maladaptive short-cut would be a parent who has unresolved trauma from an abusive childhood where they experienced violence from a parent. When their child is distressed, this parent may consciously want to protect and comfort their child, yet on a preconscious level, they may fear the child's aggression. The same principle applies in couple relationships. An additional complication is that, on the neurological level, the preconscious 'triggered' memory of their childhood abuse is often represented in the brain more rapidly and given priority (Mather & Sutherland, 2011; see also the concept of 'fast' and 'slow' thinking in Kahneman, 2011). This can result in parental aggression,

i.e., child abuse, or parental freezing, collapse or withdrawal, i.e., neglect. In other cases, contradictory dispositional representations (DRs) can lead to unpredictable and contradictory responses from the parents, or, in the context of couples, from one or both partners in a couple.

A crucial ingredient of therapy when addressing such unresolved issues is helping the person to learn how to regulate arousal and to resolve past dangers that are currently generating trauma-based psychological responses. The point is that a psychological process that was adaptive in childhood can become maladaptive later in life. To understand dangerous or problematic behaviour, we must consider both the context in which it was learned and that in which it is applied (Crittenden & Baim, 2017). It is notable that the focus on information processing and DRs as underlying adaptive or maladaptive strategies allows therapists to formulate clear hypotheses about the treatment needs and zone of proximal development of a whole family, or of specific family members. These hypotheses can be readily tested by choosing specific techniques or approaches.

Focus on the Family System and Choose Different Treatment Strategies for each Family Member

The integrative, attachment-informed perspective sees problematic behaviour and psychiatric symptoms in the interpersonal contexts of the family and the system of professionals involved with the family. This contrasts with assigning maltreatment to parents or psychiatric diagnoses to individuals. The attachment-based, integrative perspective that is informed by the DMM defines behaviour that occurs between people as interpersonal, meaningful, and dynamic, and provides a powerful rationale for working with the entire family. Assessment of attachment can reveal family members' protective strategies, the historical experiences that have shaped the strategies, and the underlying information processing that generates self, partner, and child-protective behaviour. Knowing the strategies, experiences, and psychological processes of family members can inform treatment planning (Crittenden & Baim, 2017).

The idea is not to treat 'bad' or 'disordered' parents or 'dysfunctional' or 'ill' children, but instead to promote positive changes in mental wellbeing and interpersonal functioning throughout the family. Working with a child in isolation, without addressing the family's functioning, can inadvertently set the child up for more severe danger as other family members struggle to reestablish the family's familiar functioning. For example, a compulsively compliant and obedient child who becomes assertive or emotionally expressive because of therapy may find themselves in more danger if the parent interprets their assertive communication as disrespectful (Crittenden, 2016). Or a highly argumentative or aggressive child, on trying out new responses in the home, may be called 'a weakling' or 'a wimp' (or far worse) if they don't fight back when provoked. This highlights how important it is for the whole family system to support change in an integrated way. This applies equally with adults in couples and families; changes in one partner may be supported or undermined by their partner or family members. Successful treatment may rely on support from within the family. With such an approach, professionals can help families to re-think the stories they have about each other, and to connect and support each other, rather than blame and scapegoat the supposedly 'sick' part of the family system.

Generating Family Functional Formulations Around Critical Causes of Danger, and the Critical Focus of Change

The attachment strategies represent different psychological processes, and consequently, different treatment approaches are needed for different families and individuals and sub-systems within families. Put another way, an approach that benefits one family member may harm another member of the family. This means that, during assessment, we need to learn about more than the type of maltreatment that is occurring in the family, or that family members are insecure. We also need to learn how each member of the family processes information and the strategies they use for self-protection in the family context. We also need to assess how consistent or varied the person's strategies are, and whether they differ depending on context or who they are interacting with. The risk of not doing this is that the treatment could focus on the wrong person, the wrong problem or the wrong relationship. The best and most effective treatments target the right person, the right context and the right relationships (Dallos et al., 2019, 2020).

A concept that may be helpful is the idea of identifying the *critical cause of danger,* mentioned earlier in this article. This is a danger that the person has faced which has caused them to develop a self-protective strategy. For example, the adult may have been required to learn ways of coping to deal with violence, parental substance misuse, sexual abuse, neglect, etc. in their childhood. The danger can be in the past, and in some cases, it will also be occurring in the present, for example an abusive partner, violence and crime in the community, unstable housing, substance misuse, and the threat of having children removed. When parents are faced with such past and current dangers, this makes it far more difficult to explore and reflect on strategies and adaptations (i.e., coping strategies) they have used in the past, and to flexibly try out new strategies. They are so focused on the past dangers that are unresolved, and the current dangers (some of which may be real, and some which may be exaggerated or transformed in some other way) that they have limited scope for change. Survival in the moment takes priority over adapting to hypothetical dangers in the future.

A related concept, equally important when we think about family functional formulations, is the *'critical focus of change.'* This was also mentioned earlier in this article. This concept refers to that part of a family system, be it an individual in the family, a couple, a dyad, a sub-system, or some influence on the family or context in which the family operates, which, if changed, would instigate an unfolding series of changes that would ultimately resolve other concerning aspects of the family's or individual's functioning (Crittenden, 2016). In practice, this means narrowing the definition of the 'problem' and not trying to solve every problem in the family or the individual. Focusing on the 'critical focus of change' means finding the point of maximum effect in the short, medium and long term for the individual and the family.

Taking this approach can lead to 'outside the box' interventions that may focus on structural, social and systemic changes that are integrated with interventions that are more psychological or medical.

Treatment as Incremental Experimentation within the 'Zone of Proximal Development'

Integrative treatment that is attachment-informed uses a recursive process based on the principles of action research (Zuber-Skerritt,

1996). To offer an example, treatment should offer opportunities for small 'experiments' that offer the opportunity for incremental gains and regulated 'failures' that can be treated in a supportive way that leads to reflection, revision and trying again in a new way with the benefit of the new information (Beck et al., 1979). This calls for close working with the person and the family to undertake collaborative, co-produced (i.e., not imposed) assessment, formulation, planning and intervention, with ongoing discussion and further collaborative modification of treatment. Using this collaborative approach, professionals can teach the process of integration by helping people to focus on discrepancies in informative ways. The response of the person will signal whether you proceed with the original plan or revise it as needs arise. This is what is meant by action research, a collaborative learning approach that is meant to capture the natural process of trial, error, and refinement that adaptive adults use.

Treatment should begin with the person's existing competencies and build on these in their *zone of proximal development* (ZPD) (Vygotsky, 1978). In family contexts, where the focus of treatment is the parents, the focus should be based on the ZPD of the *parents*, not the children. This contrasts with a treatment plan for the children, which would be based on the children's needs. Why focus on the ZPD of the parents and not the child? Because when the treatment plan for the parent is based on the child's needs, it might not meet the parent's treatment needs, aims or capabilities (Featherstone et al., 2018). The goal in working with the parent is to establish a process of successful change such that the parent becomes increasingly able to examine their own experience and implement more adaptive responses. As children mature, in general they become more able to process information in sophisticated ways that include linguistic, conscious, and ultimately integrative thought. Correspondingly, caregivers need to adapt to promote learning in their children's ever-changing ZPD.

The Professional may Become a Transitional Attachment Figure for the Individual or the Family

This is an important part of the therapeutic process. Where there is a relationship based on a feeling that the professional is a reliable source of support and attuned listening, one positive outcome is that the professional can serve as a role model, a container, and can help to create a cascade effect by treating the parents as we hope that they treat their children. Crittenden has written about the golden rule for interacting with troubled parents, which is to *treat parents as we hope they will treat their children* (Crittenden, 2016). This approach is enhanced when professionals understand that, for a period, they may become transitional attachment figures for the parents. If there is a basis of rapport, the relationship between the professional and the family may also be resilient enough to withstand inevitable ruptures. Crucially, such ruptures should be reframed as opportunities for attuned repair. As is the case with parent-child dyads, therapists and clients can strengthen their relationship by repairing breaches in synchrony. This is a process of reciprocal modification and can be guided by the attachment figure (that is, the most mature and experienced member of the relationship). As treatment nears completion, it is important to work through the ending of the relationship in sensitively guided ways, helping the individual or the family to direct their attachment needs to each other and to their friends, support groups, assisting agencies, etc. (Crittenden & Baim, 2017).

Repair 'Broken' Strategies and Increase the Array of Strategies

The individual or multiple individuals in the family may have strategies that are insufficient to deal with the current challenges they face. Such strategies may feel like they are broken, and this can lead to depression, disorientation, physical symptoms, and psychotic or delusional 'breaks' when the individual cannot generate strategies that fit their context. A key feature of treatment will be helping the individual to compassionately contextualize past strategy failures and to increase their flexible and integrated use of a wide array of strategies. Expanding the repertoire of strategies also means that the person gains access to all their memory systems, with no information 'off limits' to processing.

Concluding Treatment in Individual and Family Contexts

When adults develop the ability 1) to adequately reflect on their thoughts, feelings, behaviour and physical symptoms; 2) to consciously update their strategies, responses, ideas and beliefs in adequately adaptive ways, and 3) to continue to refine this process with minimal coaching and support - this is a strong indicator that treatment is nearing completion. Indicators of integration and resolution can include developing adequate strategies for dealing with triggering situations and developing healthy and conscious preventative and self-protective strategies to avoid recurrence of situations or trauma responses. Resolution can also include reflecting on the traumatising events to the degree that they are understood and placed in the past, the effects are understood, new decisions are made, new responses developed, and the events are no longer triggering when they come to mind.

In family contexts, when parents improve, children's symptoms are reduced, and child protection concerns are alleviated, parents should be guided to feel proud of their ability to adapt and to continue to adapt as a basic life process. In other cases, progress is made, but the children's needs are not met sufficiently or quickly enough. In these cases, a decision must be made as to whether changed services can help. If not, it is important to frame this as the lack of suitable services or resources (as opposed to the limitations of the parents). Blaming parents will not help them or their children, and there is much that we do not know about treatment and more that we cannot afford. In all cases, it is important to show family members what they have accomplished and how it helps them to live safer lives (Crittenden & Baim, 2017).

Conclusion

There are several advantages to the DMM conceptualization of assessment, formulation, planning and intervention. It is a theory of treatment that includes and integrates all types of treatment (e.g., psychodynamic, family systems, cognitive, behavioural, body oriented, mentalisation-based, etc. – there are more than 1,000 accredited treatment modalities) with *developmental processes*. Focusing treatment on protection and reproduction can streamline the treatment, thus lowering the cost and complexity of treatment. Furthermore, the array of DMM protective strategies gives meaning to complex and contradictory behaviour. This promotes the cooperation of parents and children.

Integrative treatment based on the DMM is principled, not packaged. It is based on the principle that we offer treatment

to *people*, not disorders. It engages parents and children with professionals, as opposed to rolling out programmes. Rather than giving people information they may be unready to use because it is outside of their zone of proximal development, the DMM integrative approach guides people to use information more adaptively (Crittenden & Baim, 2017; Dallos et al, 2019, 2020). Integrative treatment informed by DMM attachment theory is a strengths-based, non-stigmatising approach that assumes that distressed individuals have learned important things about protection from danger, and that early short-cuts in psychological processing have made it difficult for them to adapt to changing conditions. Thus, instead of focusing on maltreatment, symptoms, or insecure attachment, treatment should address safety — for self, family and others who are close — in the current context. The notion is that every strategy is the best strategy in some contexts, but no strategy is best in every context. Consequently, a major goal of integrative treatment is to increase the array of strategies that an individual can use, and then to help the individual to discover when to use each. This requires a conscious, reflective process.

The DMM definition of attachment is *learned strategies for protecting the self (and, in adulthood, one's partner and children) from danger*. Dangerous parental behaviour or behaviour in relationships is understood as misguided protective behaviour that is carried from childhood (when immaturity required psychological short-cuts) to adulthood, when it is misapplied (Crittenden & Baim, 2017). Using the DMM as an underlying framework for understanding strategies can enable professionals to make meaning of maladaptive behaviour. When professionals work with informed compassion, their relationships with clients improve. This, in turn, can facilitate adults learning more adaptive ways to care for their partner and children. When we talk with adults about the short-cuts that were essential in their childhood but are outdated now, we demonstrate respect for their accomplishment in surviving adversity. We also acknowledge their intention to protect their partner and family better than they themselves were protected, and we affirm their potential to continue learning. Adults typically find hope in the notion of life-long adaptation. This is the first step in a productive plan for change.

Author's Note

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, 2021b; Landa & Duschinsky, 2013a, 2013b, Pocock, 2010).

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Conflict of Interest

The author of this manuscript declares that there are no financial, personal, academic, or institutional conflicts of interest that could have influenced the conduct of this study, the data analysis, or the interpretation of the results.

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