DMM Integrative Treatment Forum:
Expert Panel Abstract
Patricia Crittenden, Ph.D.

1. What you consider new and important in DMM Integrative Treatment:
Integrated treatment is a universal call among those who question the efficacy of psychotherapy. Unfortunately, most such treatments throw everything at the problem, hoping something will solve it. With everything in the model, overwhelming complexity replaces ineffective simplicity. Instead, DMM Integrative Treatment is conceptualized as a dynamic, but principled, approach to diagnosis and treatment that focuses on psychological processing of information about danger, whose integration generates process that can lead to on-going adaptation.

The central thrust of DMM Integrative Treatment is to conceptualize treatment as using therapeutic relationships to initiate a process of adaptation to threats to safety and reproduction.

a. Reorganization: Psychological reorganization is the essential process that promotes adaptation. People coming to treatment are usually stuck and need to learn how to adapt to life's ever-changing contexts.
b. Development in a family context: The stalling usually occurred when the person's resources, including family members' support, were insufficient to protect or comfort them from threat. That is, to understand current problems, we must think developmentally about protective and comforting family relationships. Past and current family members are always part of treatment, whether they attend or not. Moreover, because current family members are affected (positively or adversely) by the treatment, their needs should be considered. That is, the effects of treatment ripple through family systems.
c. Adaptation and strength: DMM Integrative Treatment relies on humans' innate capacity to adapt, assuming that people are doing the best they can, given their history of exposure to danger and access to comfort. Treatment builds on strengths, using the notion that danger is an inherent part of life. Thus, DMM Integrative Treatment gives up the idealized notion of 'happily ever after' replacing it with more modest goals of anticipating and preventing threats and accommodating those that cannot be prevented.
d. Meaning: Behavior is seen as meaningful. Because this applies to both symptoms and patterns of behavior, it implies retaining the signs of problems until their meanings are understood. Meaning, however, changes over time in a recursive process.
e. Relationships: Therapeutic relationships are used to heal painful family relationships. Therapists function as transitional attachment figures to restart stalled psychological and interpersonal processes of change.
f. Informed compassion and discrepancy: Treatment involves addressing a series of mutually acceptable discrepancies, in each family members' zone of proximal development. Because most people arrive at treatment reluctantly or resentfully, establishing informed compassion is job #1. Such compassion requires listening to each person's articulation of their perspective, helping them to identify a tolerable discrepancy, and enabling them to learn ways to resolve the discrepancy. This makes it possible to build on successful experiences of resolution.

g. Assessing, formulating, and testing: Therapists need information. Initial assessment should reveal family functions that generate treatment plans and potential therapeutic actions that can be tested by implementation. Feedback on planned and spontaneous actions is used to reformulate the plan. That is, therapists enact reorganization concurrently with guiding individuals to learn to reorganize.
h. Reorganization: Reorganization is promoted by working in each person's zone of proximal development (therapists' and individuals'). Functionally, this zone can range from changing the interpersonal context in which preconscious processes are learned to using reflective functioning to regulate formerly preconscious processes.

2. Ideas/procedures that you think should be added or emphasized more:
I want to know more about regulation of arousal, especially sexual and somatic arousal, in terms of conceptualizing and responding to the issues they present in treatment. In terms of treatment, I want to know how the things we do affect different people and how we could predict that or at least recognize it as it occurred in treatment. The point would be to enable therapists to use moment-to-moment and session-to-session feedback more effectively. I'm very concerned about the power of therapeutic action that is intended well to generate harm.

3. Suggestions/experiences about applying the ideas in your setting:
My experience teaching psychotherapists (from all disciplines and with varying education) suggests that too many seek more simplicity and clarity than reality can offer – and that such short-cuts can be harmful to people seeking treatment. The complexity hinted at in my first answer is daunting – and even it simplifies human experience greatly. Therapists need to be taught early on to be humble about their powers and wary of their potential to do harm.

Most of all, I seek a way for therapists to think of their learning as a continuous process, one that operates in their unique zone of proximal development, with progress being moving forward (as opposed to passing the reliability test). That, after all, is what I hope therapists enable troubled people to do: find discrepancies, reflect on them, learn from them, then take the next step forward. Hope lies in negotiating the next step and using that as the evidence that you'll manage the one after it. Too much focus on an ultimate goal can defeat you. Making progress, step by step, gives hope. Knowing how you did that gives hope a basis in reality.

Finally, I think the DMM is as complex as any other theory of treatment; indeed it encompasses many theories. Schools that teach treatment require several years of training to qualify emerging therapists. Why would anyone expect to grasp all of the DMM in 3 days of A&P or even 3 weeks of the AAI? Human suffering is complex. Any theory that describes it adequately for application must be complex. The actual applications must require more effort yet. To expect a theory of human adaptation to be simple is to risk harming the very people who come or help. I think professionals who dare to intervene in the daily lives and suffering of other people should be willing to undertake a very substantial program of learning and to accept that learning will be on-going.

(With apologies for length. Ask a theorist and you'll get a book.)

DMM Integrative Treatment Forum:
Expert Panel Abstract

David S. Elliott, Ph.D.

1. What you consider new and important in DMM Integrative Treatment:

A central contribution of the DMM integrative treatment is the emphasis on the systemic factors that contribute to the formation and perpetuation of attachment strategy patterns. Recognition of these factors allows for treatment interventions to include the systems that patients are embedded within, particularly parenting and family systems. Changes within and across systems will affect individuals' experiences and responses, ideally toward more coherent and less defensive functioning. For each individual in treatment, specification of the dispositional representations and attachment strategies used, and recognition of the "zone of proximal development" at each phase of treatment, allow for very tailored and focused interventions toward changing the information processing patterns relevant to attachment circumstances. The concept and practice of developing a comprehensive functional formulation is very valuable.

2. Ideas/procedures that you think should be added or emphasized more:

My work brings explicit focus to three areas that are included but could be more developed in DMM IT:

1. Re-mapping dispositional or attachment-related representations. Beyond the therapist as a transitional attachment figure, focused imagery of engaging with "ideal parent figures" efficiently establishes new, healthy attachment representations.
2. Enhancing reflective function. Explicit attention to reflective capacity and its enhancement throughout treatment supports emerging attachment security and assists in the integration of treatment gains at all phases.
3. Highlighting the collaborative aspects of therapy. Collaborative capacity is impaired in people with attachment disturbances, so explicit attention to collaboration throughout treatment brings benefit.

3. Suggestions/experiences about applying the ideas in your setting:

When I treat parents for their attachment disturbances, after some time I frequently hear statements such as, "I'm finding that I'm loving my children more." A nice validation of the perspectives and practices that DMM IT embodies!

DMM Integrative Treatment Forum:
Expert Panel Abstract

Steve Farnfield, Ph.D.

1. What is new and important in DMM Integrative Treatment?

I think the answer to the above question is the DMM approach to information processing. The focus of the DMM-AAI on memory systems lifts assessment from general ABC classifications to a person specific analysis which offers the clinician an entry into helping a particular client.

In addition the combination of assessment procedures (CARE-Index, SAA, AAI and so forth) enables a holistic approach to family problems.

2. Procedures that should be added.

While the parents interview is a means of accessing information processing around caregiving we still need to move theory and assessment from the dyad to the family system. One way of doing this would to use a procedure like the Lausanne Trilogue Play Paradigm (which involves both parents playing with their child) and coding it using DMM constructs.

3. Suggestions about applying the ideas in a University setting.

In the University we will investigate the bio-physical correlates of information processing in adults by using the AAI with video and physiological measures such as heart rate variability, cortisol and alpha amylase.

I also have a Ph.D. student looking at family systems and attachment with the LTP as one of the procedures.

DMM Integrative Treatment Forum:
Expert Panel Abstract

Agnieszka Klimowicz, M.D.

1. What you consider new and important in DMM Integrative Treatment:

Focus on current and past danger (s), well defined unresolved trauma/loss,
and focus on the family

2. Ideas/procedures that you think should be added or emphasized more:

Difficult to say at this stage; I work in a context in which formal family therapy is rarely available, but family work is carried out regularly mainly by nurses working alongside me; I work in the context in which a patient is the mother with 'severe mental illness', frequently referred at the point when she is pregnant and well (Bi-polar affective disorder, schizophrenia, schizoaffective disorder, history of very severe depression with suicidal acts) or/and complex psychological problems (a few ICD-10 diagnoses when coded);

3. Suggestions/experiences about applying the ideas in your setting:

So far – I use DMM to aid the diagnostic and engagement process.

DMM is useful in better understanding of problems hidden behind the symptoms in the one off consultation process, or when I do extended assessments, which I usually 'translate' into

the language understood by professionals not formally trained as psychotherapists (nurses/social workers) who support patients and their families.

I am slowly introducing AAI and CARE-Index in the work with mothers with complex psychosocial problems;

I see a clear potential in better understanding of the people diagnosed with severe conditions who seem to use A4-A7 strategies (as seen in the consulting room and their behaviour described by family or professionals, not as assessed with AAI);

In the future, I am thinking about using the AAI with patients diagnosed with borderline personality disorder for whom psychotherapy in the community is not an option (e.g., too risky behaviour to be in the community)

I started using DMM ideas in individual psychotherapy – I do not have enough experience yet to say if it enhances the outcomes.

DMM Integrative Treatment Forum:
Expert Panel Abstract

Andrea Landini, M.D.

1. What you consider new and important in DMM Integrative Treatment:

The newest and most important feature of DMM integrative treatment is, in my opinion, the focus on protection from danger. This angle allows an integration of ideas and evidence from: 1) observational studies of interaction in family relationships, 2) neuropsychology of human processing of information, 3) human development, 4) interactive shaping of processes of change. This integrative perspective on protective strategies allows selection of priorities among treatment-relevant information and treatment goals in innovative ways.

2. Ideas/procedures that you think should be added or emphasized more:

Individual differences in development and strategic organization are neglected as "maladaptive behavior" captures everybody's attention. The "content" of the problems too often obscure the processes that generate and maintain the problems. Assessment of the whole family's organization of protection from danger (the interplay of the individual strategies in the context of the family) is neglected in favor of understanding isolated individuals, or understanding the immediate antecedents or consequences of symptomatic behaviors. A developmental framing of the family processes should also receive more emphasis. Accordingly, practice with the idea of the therapist as attachment figure for the whole family could be encouraged.

3. Suggestions/experiences about applying the ideas in your setting:

My most striking recent experiences are in the training of psychotherapists. I am impressed by how often I have to highlight that if attention is focused on the individual's "disorder" or even protective organization, we really know very little about the conditions that promoted such an organization, and about the reasons why the organization is currently maladaptive. In other words, despite being theoretically aware of the importance of the ecology of danger and protection, therapists need to be helped to bring the theory in line with their practice, first in assessment, then in planning a treatment setting that draws on assessments' result (rather than on a standardized, one-size-fits-all procedure that the therapist identifies with

DMM Integrative Treatment Forum:
Expert Panel Abstract

Martin Stokowy, M.D.

1. What do you consider new and important in DMM Integrative Treatment?
   Using DMM ideas in a psychiatric hospital, where the thinking is based on psychoanalytic and family systemic theory, is still very productive.

   Besides the biological functioning background of DMM ideas, it is very helpful to distinguish basically between attachment, explorative and panicking behavior, when we want to figure out the meaning of the presented behavior of an inpatient or a day patient. Even more important with psychiatric inpatients are the ideas of adaptation to early experiences of danger and of regulation of arousal, both as diagnostic tools and treatment goals.

2. Ideas/procedures that you think should be added or emphasized more
   To me, a major problem for the clinical usability of the DMM was the very strong emphasis on the use of the complex DMM diagnostic procedures. To my impression, I found a different notion in the second edition of "Raising parents", especially with the use of the analysis of information processes of treatment episodes, which were not derived from any formal assessment, like the AAI or TAAI. This different notion makes it easier to accept DMM ideas, without having the feeling, "oh, will I have to learn all or some of these procedures? Will I ever be able to use them in everyday clinical situations?"

3. Suggestions/experiences about applying the ideas in your setting.
   We use DMM ideas regularly in everyday life in our daily rounds, during case conferences and especially on our Parent-infant-ward.

   In my discussion with local mental health authorities or youth welfare offices, I got the impression, that there is a bias of, let's call it, C-families over A-families in terms of consuming support from local authorities; and I found the readiness of the authorities astounding to offer ever more of these, without monitoring the suitability of any of the offered measures. Are there published data on this topic?

   What about the fathers in attachment theory?

DMM Integrative Treatment Forum:
Expert Panel Abstract

Victoria Lidchi, Ph.D.

Vicky Lidchi cannot be present but sent the following abstract:
This presentation will use some of the concepts explored in the DMM Integrative Treatment model to understand the presentation of children and young people with complex health education and social care needs. These children and young people have equally complex family and care histories, marked by trauma and abandonment.

Family networks are often replaced by complex network of professionals who struggle to work with and plan for these children or young people and their families. The DMM Integrative Treatment model offers a way to organize information, formulate an understanding of presenting problems and integrate treatment modalities, as well as for restructuring of the interpersonal environments around these children and young people. This in turn frees them to experience close personal relationships in a different way, and in the longer-term revisit expectations of threat and danger represented by intimacy.

Case examples illustrate interventions that have failed and those that have been more successful, and ideas from the DMM Integrative Treatment perspective to understand different outcomes, bearing in mind one of the original tenets of Bowlby's work around "maternal deprivation". This is that experiences of interpersonal relationships are crucial to children's psychological development, and that the formation of ongoing relationships with the child is an important part of parenting alongside the provision of experiences, discipline and child care in any "home" setting.