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Teaching mental health colleagues how their own attachment strategies may distort their clinical responses and judgements, by using video clips portraying child abuse.

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Topic: Clinical practice

I have offered a wide range of health and social service colleagues, including students, an experiential insight into their own attachment strategies, and the possible outcomes. I show them 15 minutes of a UK commercial TV documentary, first shown in 1999, which focussed on the covert surveillance of parents with children, suspected of factitious disorder by proxy filmed in special USA and UK wards. The training session is introduced as '*potentially informing them about something important, including about themselves',* when dealing with serious clinical situations and child protection'. I note it is a commercial TV recording, on factitious disorder, and check who has seen it before ('noone' n=200+!). I stress that whilst they will learn something about factitious disorder, that is not the sessions' main purpose. I then watch with them, where the parents shown are clearly a) initiating vomiting by using their fingers to elicit a gag reflex, and in b) the parent smothers the child with their body to reduce oxygen saturation-and then both alerting and deceiving the staff. I then invite verbal responses from each of the group, as 'comments?' and write these on a board, together. The majority immediately provide denotative language; minimising, "*a bit.*.", distorting, "*interesting*", and on a few occasions, "*no, it's made up-they are actors*". I go through highlighting the offered language effects of past tenses, semantic wraps, and occasional philosophical question. Sometimes, there are vivid first connotative responses-"*fucking hell*", and we discuss how the language differs in being led by feeling or thinking. The session concludes looking at historical media reported pattern of repeated missed cases and the professional responses.

How it used the DMM

For students this is a first introduction that they have a self protective strategy when faced with-allbeit- vicarious distress, and I introduce the DMM system of attachment; and for colleagues, a surprising reminder despite their experience, that they have mental representations impacting quickly and explicitly in changing/distorting ways. We discuss the findings of Lambruschi, that therapists tend to be A strategy-'who else would care to prioritise others' discomfiting distress, or their houses, but also that these same professionals are most at risk, of distorting or cutting off affective information when psychologically overwhelmed. *Victoria's legacy DMM NEWS 4 Sep 2008*.

What it can contribute to the DMM

The lessons of high profile cases are not sufficiently learned, despite Laming's (2003) erudite report on Victoria Climbie. The lesson of false positive affect, well understood by the DMM, is still habitually missed, and the crucial but predictable maladaptive professional response to stress is still hardly recognised. Stretched services described by Menzies-Lyth in the 1960's, continue to be organised around

maladaptive responses - *"just a quick telephone triage risk call to see if you are OK after your recent suicide attempt"*. The DMM offers an opportunity to understand these repeated maladaptive service habits, to offer a framework that there is a developmental psychopathology, as an alternative to reliance on nosology, that can assist in understanding. Maybe the DMM can identify the strategy to bridge the professional gap?