The use of the Dynamic Maturational Model of attachment and adaptation within a systemic setting in CAMHS
Katrina Robson & Annette Wetherell

CITATION
Reflections on collaborative working: Library support to clinical practice

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Abstract
This paper describes a service for families that has arisen from collaboration between the family therapist and child therapist in Child and Adolescent Mental Health Services (CAMHS) in South Cumbria.

Keywords
attachment; dynamic maturational model; family therapy; play therapy; CAMHS

Introduction
As CAMHS practitioners who have worked in the same team for a number of years we have attempted to adapt to the changing nature or referrals and the need to develop services which address the complexity of family relationships and functioning. As a result a new working alliance has grown and developed within the South Cumbria CAMHS specialist
team which we thought may be of interest to other practitioners. Partly this new way of working has evolved as a result of a growing awareness that some children/young people and their families need something more comprehensive than individual therapy or family therapy. We recognise that there is a real need for services that are family based and which reflect the developmental nature of mental health problems, bringing together adult mental health and child mental health services (Department for Children, Schools and Families, 2009; Pike, Coldwell & Dunn, 2006 Social Care Institute for Excellence, 2009; Field, 2010; Centre for Excellence and Outcomes in Children and Young People’s Services, 2011). Findings from a recent study of adult attachment interviews (Crittenden, Landini & Pistolesi, 2009) suggest that parents of children referred to mental health services are often as troubled as adult patients in psychotherapy.

**The beginning of our collaboration**

As practitioners, we started to consider bringing together our approaches thinking that this could improve families’ experience and their use of therapy and enhance our respective theoretical understandings.

As family therapists, we work with families to deconstruct the meanings that they or others make of their difficulties. This means that we often shift the focus away from the problem-saturated narratives (White & Epson, 1990) towards developing the families’ interest in broadening their shared understanding of the difficulties. This promotes thinking about difficulties in the context of relationships rather than behaviours or problems. Family therapists facilitate and embrace multiple perspectives, believing that the sharing and understanding of these different experiences and perspectives will strengthen family relationships and change their relationship to the problems (Anderson, 1997). What we have found, however, is that there are times when the child's experiences are so different from the parent's, particularly when working with adoptive or foster families, that enabling the child's voice to be heard has been more difficult. This is particularly so when parents are facing many challenging and puzzling behaviours.

Play therapy offers the child a safe place to feel accepted just as they are and to explore and express their feelings, thoughts and experiences symbolically. The child can use an age-appropriate means of communicating with the therapist (i.e., play) and will receive empathic and congruent responses to enable them to articulate and potentially resolve painful issues. Equally within play therapy there is an ongoing debate about the question of whether and how individual play therapy can assist a child who is considered to have ‘attachment difficulties’. This has led to a number of postgraduate trainings which advocate including parents in direct work with children. As a consequence of these dilemmas and developments, we became increasingly interested in how to understand the adult's contributions to family functioning and in how to help parents understand more about the child's struggles with attachment.

In order to address these clinical dilemmas we began to experiment with two different approaches that combined systemic approaches with the use of the Dynamic Maturational Model of attachment and adaptation (DMM; e.g., Crittenden, 2005). The DMM was developed by Dr Patricia Crittenden who studied under John Bowlby and Mary Ainsworth, both pioneers of attachment theory. With their approval and collaboration she has extended their work to develop a series of age-salient assessments across the life span (Crittenden, 2008). We used two of these assessments The first was the School Age Assessment of Attachment (SAA; e.g., Crittenden, Kozlowska & Landini, 2010) to inform work with parents without the child being engaged directly in the therapy. The second was the Adult Attachment Interview (AAI; e.g., George, Kaplan & Main, 1996) to inform the adult work in family therapy alongside play therapy being undertaken with the child.

**The use of the SAA within a systemic framework**

We have increasingly found that the presenting difficulties of children referred to CAMHS can best be understood and worked with within the context of family relationships. Often the child's seemingly problematic behaviour has a function within the family which needs to be thought about systemically, rather than being located within the child. This is a particular challenge when it comes to looked after or adopted children who have often arrived in the family with the label of ‘attachment problems’.

Understanding the child's behaviour as dyadic or familial rather than simply an individual disorder means the complexity of family relationships needs to be understood (Robson & Tooby, 2004). Because of this, there are times when it is better to work with the parents in the first instance. The SAA can provide
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invaluable insight and credibility when working with the parents alone.

The SAA allows us a small window into the child’s world without engaging them directly in family therapy. It is an assessment of a child’s psychological strategies using picture cards. It is taped and transcribed and is analysed to identify not only the child’s underlying attachment strategy but also the unresolved issues of loss and trauma which affect day-to-day functioning. Consent is sought from the child and parents for the SAA to be undertaken and shared with the therapy team. In practice we have found that the learning from the SAA gives an authenticity to our work and allows all of us to grow together in understanding the child and why they might be doing the things that they are doing. The understanding gained is then used to shape and inform the discussions with parents in therapy. The model we use is to have a lead therapist who talks with parents for a proportion of the session. This conversation is witnessed by two other therapists who are also in the room; the play therapist who will have undertaken the assessment, and a family therapist. The reflecting team therapists have a conversation in the presence of the parents and the lead therapist about what they have heard. This allows the parents to stand back and listen to the discussion. The play therapist is able to stand in the child’s shoes and give voice to the feelings underlying the behaviours. The reflecting team can also develop ideas, pick up on threads of conversations that could usefully be further developed and enquire into areas as yet unexplored. The collaboration between the family therapist and the play therapist means that the different skills, knowledge and understanding are brought together for the benefit of the family.

After the reflecting team has spoken, the family can then respond to what they have heard. This often leads to the new understandings becoming more confirmed and embedded into parents’ thinking. The systemic principle of appreciating the validity of all the perspectives within the family creates a safe environment in which to embrace new understandings, both for the family and the professionals. It also means that each perspective can be understood and then evaluated in terms of the basic family functions of providing protection and comfort within the context of family relationships. This allows us as therapists to remain child focussed and to prioritise around promoting safety and comfort.

This model has the benefit of enabling the attachment ideas to become more real to parents because the ideas are directly related to their own unique experience and the conversations they have had in therapy. In addition, the learning from the SAA informs the therapist, the reflecting team and the parental discussions and can help make sense of puzzling behaviours.

The use of the AAI within a systemic framework

Within the systemic field, attachment ideas have been embraced and integrated into an attachment narrative approach (Dallos, 2006). Although these ideas have been helpful and informative, we have found that listening to adults’ own stories in therapy does not always provide access to the unprocessed or hidden stories that affect behaviour without conscious awareness. The AAI provides a window into the experience of the speaker behind the words so that it is not the content that is crucial but rather the way it is related linguistically and through the relationship with the interviewer. Once recorded the AAI is carefully transcribed and coded so that it can be given thoughtful and ongoing integrative consideration by the therapist. This seemed to us to be an extremely helpful option. It is apparent that there is now some recognition of the fact that adult attachment can be a significant factor particularly when it comes to families who face complex problems or use entrenched patterns of relating. The DMM (Crittenden 2008) provided us with an opportunity to begin to understand the complicated nature of attachment and family functioning.

Many child therapists would now agree that there is a need for parental work to be offered alongside individual child therapy. What has been a step further in our team is to see the child’s problems in the context of the family and to use the AAI to guide the qualified family therapists to treat the parents. The DMM-AAI (George, Kaplan, & Main, 1996 and extended by Crittenden 1995) is an interview for assessing adults’ strategies for identifying, preventing, and protecting the self from perceived dangers, particularly dangers tied to intimate relationships. The AAIIs give us an insight into attachment self-protective strategies and unresolved issues of loss and trauma which impact upon families in ways that may be unconscious, unprocessed and therefore difficult to access. This allows us, as therapists, to join with a parent in understanding how it is for them and how they experience their child.
Parents often struggle to see the relevance of their early history on their present difficulties and therapists can feel lost, particularly when faced with long and detailed personal narratives. The content of the interviews along with the discourse analysis allows us in therapy to link the parents’ much needed self-protective strategies with present patterns of relating to their children. Recognising significant memories and distorted thinking brought forward from the past can help us as therapists to attune to the unique detail of the adult’s life and can make the connections much more real for parents. Experiencing this enables parents to begin to recognise their contribution to their child’s difficulties and to feel empowered to make changes. This also seems to help develop empathy towards themselves, their child and their child’s behaviour.

Ongoing discussion about the interviews continues to take place between the therapists as the work unfolds, allowing the learning and insights from the interviews to be thought about as needed. This also allows for an appreciation of the function of the attachment strategies in the family.

Conclusion
We started this article with a reference to the increasingly complex nature of referrals to CAMHS. Appreciating and working with complexity can be a real challenge but we both share a belief in the healing power of relationships and an awareness that no one theory has all the answers. Working together has enabled us to learn from each other and to sustain hopefulness for the families with whom we work.

We have found that the use of the SAA and the AAI has enabled us to look under the surface and identify the particular issues which lie in the histories of parents and impact upon the relationship they are able to have with their child. Once identified, parents can then be helped to see their contribution and feel more in control of doing something about it. It has also meant that we have been able to focus upon and address the most troubling problems immediately, thus saving time and resources. The DMM assessments enable us to formulate problems as dyadic or familial issues rather than individual disorders or lists of symptoms. In services that are divided into child/adolescent or adult mental health, lack of resources and tight team specifications often prevent the integration of services that could be structured to address the needs of the adult parents in addition to the needs of their child. Indeed in many cases this work is crucial to the success of any child therapy. Many parents who have children who are referred to CAMHS have their own long standing mental health difficulties. Also these families are often the ones that return to agencies again and again, having sometimes been offered short-term programmes of intervention which produce results that are impossible to sustain unless the underlying issues are addressed.

For us as clinicians in a child mental health service we have an obligation to remain child centred and working in the way we have described provides a way to do this whilst also standing in parents’ shoes. This means we can be a bridge between parent and child, allowing empathy and understanding for the child that the parent once was whilst holding the referred child in mind so that the parent, having received empathy for themselves can increasingly empathise with their own child.

Finally we would like to acknowledge the openness of the families with whom we have worked. It is sometimes a challenge for parents to begin to think about understanding diagnoses and mental health issues in a relationship context and we are aware of the trust they place in us as professionals. We very much want to ensure that our service is a reciprocal process and that the feedback we receive affects the structure and process of what we do. With the families consent we therefore end with their words: “As a family we have been receiving family and play therapy for some time. We completed the family attachment interviews which highlighted things we would never have thought about before. By being open and honest and sharing information it has helped us to understand issues and find ways of helping our son.”

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