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Adult Attachment Interview Special Issue # 2

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Second special issue dedicated to the DMM-Adult Attachment Interview

It is a pleasure to present you the second of the three issues dedicated to the Adult Attachment Interview based on the Dynamic-Maturational Model (DMM-AAI). As in the previous newsletter, three AAI trainers discuss its application in different fields (clinical, forensic and research).

The first two articles highlight the difference between clinical diagnosis with its accompanying symptoms and a dynamic and structural understanding of self-protective strategies. They point out the danger of pre-conceptualizations derived from clinical symptoms. 'Trend diagnoses' such as depression tend to obscure what is needed for change and to perpetuate pathology. Similarly, it is not enough to record the mere presence of violent behavior and to prescribe an anti-aggression treatment. Understanding the function of violence in the individual's context, as experienced subjectively during development can shape a safer treatment, which can help to prevent relapses into violence.

Martin Stokowy describes a case in which the information from an AAI revealed that the presented symptom of depression as part of bipolar disorder served a hidden function within an obsessive attachment strategy. The patient's hidden need for 'rescue', interwoven with unresolved losses and the unconscious fear of becoming fatally forgotten, the display of being depressed attracted professional help. On the other hand, that display misled both the patient and professionals to treating the 'wrong' problem, leading to a vicious cycle of ongoing and irresolvable suffering.

Val Hawes gives us a glimpse into the work on a forensic unit in the UK, highlighting the importance of differentiating the function of anger and violence of dangerous patients. In order to provide an appropriate treatment and risk assessment, professionals need to know whether the man's anger takes the form of an 'eruption' of forbidden feelings within a highly inhibited self-organization or is enacted as an instrumental display to deflect from feelings of vulnerability and fear.

In the third article, changes of attachment strategies according to the child's need to adapt to its parents' self-protective strategies are described by Airi Hautamäki. She presents two longitudinal studies showing that stability of attachment across individuals' development and continuity across generations is greatest in less endangered populations and least in endangered, at-risk populations. She proposes that this is because children need to adapt to the 'missing piece' of their mothers' type of information processing.

As usual, at the end of the newsletter, there is an alert to upcoming DMM courses. For more information, you can check The Family Relationship Institute website www. familyrelationsinstitute.org.

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Making Sense of Depression:

Use of the AAI with a Patient on a Mother and Child Ward

Introduction

A woman was admitted to the mother and child ward of our psychiatric hospital. She had the diagnosis of severe depression in the course of a bipolar II disorder. She was in her late 30s and her daughter was one year old.

The woman was on medication (Lithium, SSRI) and her psychiatric history was very difficult to complete. We contacted her psychiatrist and were intrigued that the patient showed up at her practice only when depressed. Our discussion with the psychiatrist did not reveal much content in their contacts.

We contacted her psychologist, who revealed that the patient had reported having different states of activity, e.g., staying in bed for several days, and then rushing around and spending money. That is why he suspected a bipolar II disorder.

On the ward, the woman complained about sleeping problems, and these were resolved easily by low dose promethazine. She presented as stable in mood.

On the weekend her husband, who runs a business, stayed in the hospital, and she commented afterwards that her husband was very passive. She experienced somatic symptoms, which had not been present since the day of her admission.

Then her mother-in-law suffered a neck fracture. For a short time, it seemed as if our patient would interrupt treatment in our hospital because of her mother-in-law's accident, but she decided deliberately to stay.

Analysis of the AAI

Besides taking the patient's medical history, we offered her the Adult Attachment Interview. The transcript was coded by a qualified coder, knowing that this was an AAI from an inpatient mother on a psychiatric ward, but with no further information.

The AAI was classified as UI (p) Father Utr (ds) brother C5-6. One notable feature of the classification was the clear lack of depression. The pervasive affect was fear. She described herself as being tough and invulnerable. She seduced the interviewer to draw conclusions for her, and she acted in a disarming manner. She idealised in a triangulated form, i.e., she idealized her maternal grandmother in order to derogate her mother.

The loss of her father several years ago was unresolved in a preoccupied manner. For the death of her younger brother, she had an unresolved but dismissed trauma (when her brother was 1 ½ and the patient was 5, he suffocated in his cot after choking on his vomit). She appeared to experience, on a subconscious level, the constant fear of being totally forgotten about, because such neglect could have, as in the case of her younger brother, deadly consequences.

Anger and fear were both present, in an alternating form; desire for comfort was almost entirely missing from the transcript. Her father's violence appeared on a psychological level to be less endangering than the neglect from her mother, as he somehow cared for her, although he would also beat her. Despite the violence, her father was represented as protective. Framed this way, aggression appeared to stabilize her psychic structure, although it had fearful aspects.

Conclusion

For this patient, it appeared that her self-protective strategy was to present with depression. This helped to bring her back as the focus of attention in her family. When this did not work, she looked for strangers to care for her. Because we were able to understand the underlying psychic function of her depression, we were able to understand why she showed no signs of depression while she was in the hospital. With the classification of the AAI, we were able to add meaning to the symptoms the patient revealed and their function in multiple relationships.

(With kind permission of the patient)

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Endangered *and Endangering*

Val Hawes

Introduction

In recent years there has been an enormous increase in the literature – books, research papers, articles – on applications of attachment theory in clinical practice. This has included developments of attachment-based treatment for individuals with a wide range of severe psychopathology, all of which may be seen as a reflection of 'disorganized attachment.'

The Dynamic-Maturational Model of Attachment and Adaptation (Crittenden, 2008; Crittenden & Landini 2011) provides an alternative approach to the assessment of severe psychopathology, with recognition of a wider range of attachment patterns that have developed as self-protective strategies in response to dangers encountered during development.
These attachment patterns can be assessed using the DMM-AAI.

The Fens Unit

The Fens Unit is a therapeutic unit within a high secure prison developed since 2000 as part of a UK Government strategy for the assessment and treatment of high-risk offenders diagnosed as suffering from severe personality disorder. The DMM-AAI has been in regular use at the Fens (DSPD) Unit for 7 years, with more than 40 interviews having been completed mostly during assessment, but a few on completion of the 5-year treatment programme.

Findings from the DMM-AAI

Just over a quarter of these interviews have been fully analyzed using DMM coding and classification. These classifications show both consistent features and a variety of patterns. The main consistent feature is unresolved trauma, i.e., all the offenders have experienced significant trauma during development, particularly issues of neglect and abandonment, physical abuse by attachment figures, and sexual abuse, either within or outside the family. In many of the transcripts, there is evidence of more than one type of unresolved trauma, e.g., physical abuse by father and sexual abuse in care. Across the transcripts, there is also a frequent finding that lack of resolution of trauma in a single transcript is expressed in several different ways.

This consistency concerning trauma contrasts with the variety of classification patterns seen in these high-risk offenders. The majority of patterns are high subscript, i.e., lower half of the DMM circular model, but include Type A (cognitive strategy), Type C (affective strategy) and combinations of both A and C strategies, including the integrated AC pattern that is the DMM representation of psychopathy.

One major issue of difference between Type A and Type C relates to deception – whether or not it is evident and if present, the seriousness of it. The transcripts of Type A speakers tend to be factual and unemotional (even when describing severe victimisation) and these individuals take responsibility for their own actions. They may withhold information but it will be clear that they are doing so. The transcripts of Type C speakers tend to be less ordered or coherent, with clear affect and with evidence that the speaker was deceived by attachment figures. There is also deception within the interview, e.g. presenting self as victim while omitting own contribution to events.

Benefits of using the DMM-AAI

Knowledge of these differing attachment strategies can contribute to both an understanding of offending and also to planning treatment. Most violence occurs in the context of dysregulated affect/anger. For effective treatment, it is important to recognise whether anger is habitual (Type C) or rare explosions in an otherwise inhibited individual (Type A) or absent, as in those with callous/unemotional traits of psychopathy (Type AC).

Conclusion

People with all types of attachment strategy need help with affect – those with Type C need help to get in touch with vulnerable or 'forbidden' affect, while those using Type A strategies need help to experience and safely express negative affect. People using Type AC strategies need help to get in touch with the full range of their feelings. CBT programmes alone are unlikely to achieve the needed change and may be particularly problematic for individuals using a Type A strategy (the risk is that CBT-based programmes may strengthen inhibition of affect, with risk of more intense explosions in future). Thus, without understanding of the affective aspects, clinicians may unwittingly collude with existing patterns.

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Airi Hautamäki

A Transgenerational Perspective on Attachment: *Continuity and Reversal*

Introduction

A Chinese saying points out "Look at your grandchild and you'll know what kind of parent you have been." Empirical research based on the ABC-D model has indicated continuity in attachment across three generations, particularly in regard to secure attachment. The results are the same if the data are analyzed retrospectively, concurrently, prospectively, or with the help of meta-analytic studies (Benoit & Parker, 1994; Van IJzendoorn, 1995).

Are attachment patterns static traits, being transmitted somehow from one generation to the next? The DMM does not predict continuity across an individual's lifespan or across generations. The DMM stresses the contingencies of safety and danger that parents tend to create for the child. The child develops his attachment strategy to cope with danger connected to his parents and the more distal environment. The DMM addresses change, treating adaptation as the dynamic fit to context, i.e., the relation of strategy to parental contingencies and contextual dangers (Crittenden, 2008). Maturation creates possibilities of change in developmental pathways. If there is danger, the DMM predicts more complex organization both across the individual's development and across generations.

Recent research findings

Two recent studies have addressed the transgenerational transmission of attachment using the DMM methods: The three-generational study of Hautamäki et al. (2010a, b), and the two-generational study of Shah et al. (2010). Hautamäki followed a low-risk sample (N =135) of primiparous parents and maternal grandmothers from pregnancy until the child was 3 years old. The AAI interview was used to assess attachment in mothers, fathers and grandmothers during the last trimester of the mother's pregnancy. Shah's prospective study comprised of 49 normative primiparous mothers and their infants. Hautamäki et al.'s study indicated that Type B was stable across three generations, and Type A, predominant in the sample, showed some continuity. Additionally, a tendency for pendulum swings across generations, i.e., reversals to the opposite strategy, were found among Type A and Type C. Likewise, Shah et al.'s study found the match between Type B mothers and babies, but a tendency for inversion of anxious patterns of attachment.

Discussion

Why would that be? Types A and C are psychologically opposite strategies. Type A is oriented at temporal contingencies of stimuli, and Type C at the intensity of stimulation. The child develops a strategy that fits the mother's expectations by contributing the "missing" piece to the information processing of the mother. In particular, when parents have experienced danger, their ways of caring for their child may create a threat to the child, who will organize his or her attachment strategy around the threat. An easily angered and frightening mother using a Type C strategy may elicit a compulsively compliant Type A strategy in her child, who in turn may not be capable of restraining anger in her own child, and may raise a child who uses the Type C strategy. A depressed mother may elicit a compulsive caregiving strategy in her child that functions to keep the child in touch with the withdrawn mother. Low-numbered anxious strategies may produce reversals, too. A mother using a Type A strategy who wants to be more available and express her

feelings more openly than her parents did when she was a child may not be able to establish an authority relationship, only prioritizing her child's perspective and silencing her own, thus involuntarily reinforcing her child's expression of negative affect (i.e. development of a Type C strategy).

Conclusion

The DMM offers one plausible explanation for the fact that stability of attachment, both across individual's development and generations, is greatest in middle-class, less endangered populations, and the least in endangered, at-risk populations.

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Upcoming 2014 DMM Courses

In 2014, there will be courses in Attachment & Psychopathology (North America, Germany, Ireland, Sweden, and the UK), the CARE-Index (many countries), CARE-Index Toddlers (Italy), SAA (Italy), TAAI (North America), AAI (Ireland, Italy, UK, USA), & Parents Interview (UK) and numerous advanced courses. For dates and locations, check www.familyrelationsinstitute.org.

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