No. 21, NOV. 2015
DMM news
www.iasa-dmm.org
The international association for the study of attachment
iasa

DMM Integrative Treatment: Bumps in the Road to Change

Note: This plenary session at IASA's 4th conference was delivered in humorous repartee between 'Slick' Dr. de Bernart and 'Thick' Dr. Landini. Together, they enacted the processes they described. IASA hopes to post the videos of the plenaries on its website (www.iasa-dmm.org)..

DMM Integrative Treatment is the application of theory, assessment, and clinical practice about attachment and adaptation to intervention and treatment. The IASA Working Group on DMM Integrative Treatment considered the goals and processes of effective treatment in meetings from 2008 to 2015.

The Goals of DMM Integrative Treatment

The DMM focuses on family members' strengths rather than deficits and on self-protective strategies rather than symptoms. A major goal of DMM Integrative Treatment is to re-activate the stalled or disabled self-organizing adaptive abilities of individuals in treatment. This is in contrast to removing deficits. Restoring each person's trust in their own mind's ability to generate adaptive self-protective, partner-protective, and child-protective strategies and to test a strategy's appropriateness before using it may be the most cost-effective way to optimize our limited resources.

To accomplish this, therapists help people to reconstruct a past that they cannot fully articulate, and prepare for a future that they cannot yet imagine. "Bumps in the road" are opportunities for shared exploration and interpersonal repair of psychological and interpersonal processes.

Five Central Processes of DMM Integrative Treatment

The five processes described below are sequenced, but also recursive, with many steps being repeated differently as the treatment progresses. One can think of therapy as an expanding spiral that re-covers old ground, with greater integration each time.

1. Establish a transitional attachment relationship with each person: This is best done during the assessment process; it assists therapists to work in each family member's zone of proximal development;

2. Repair strategies that are currently malfunctioning: Usually this implies that the strategies do not fit the context in which they are applied;

3. Resolve psychological traumas: This involves reviewing information about past experience of danger and considering its current relevance (so as to limit maladaptive interference with current functioning);

4. Increase the array of protective strategies that family members can use: Tie each strategy to the contexts in which it is appropriate and adaptive;

5. Model and engage the family members in the process of integration: Not all treatment will include this, but it increases resilience and adaptation to unforeseen future circumstances.

Assessment of Protective Strategies

A crucial basis for treatment is identifying individuals' ways of making meaning of experiences of danger, safety and comfort (that is, multiple dispositional representations or DRs). Because DRs reveal aspects of family functioning, they can inform therapy. Families are inherent to treatment even if the treatment is to an individual. Assessing DRs is central to establishing therapeutic relationships and treatment planning, particularly producing Family Functional Formulations (FFF). Some 'slick' therapists use continuous informal assessment, whereas other 'thick' therapists prefer the precision and detail of systematic use of DMM assessments. Good assessment helps to prevent iatrogenic harm from misapplied treatment.

Family Functional Formulations & Treatment Planning

FFFs articulate hypotheses about the critical dangers for families and therapists. Critical dangers organize the interplay of family members' protective strategies and therapists attempts to add flexibility to these. Although planning is an explicit process, treatment during therapy sessions is largely regulated by therapists' implicit DRs. Some of therapists' DRs represent past professional experience (procedures, images) and reflect what has often worked or not worked in the past. Other therapist DRs reflect the therapists' own protective strategies, the current dangers for the therapist, and past experiences with danger; these can interfere with therapists' focus on the person in treatment. Danger to therapists is particularly important when mistakes can lead to public censure, legal action, or being fired.

Implicit representations can become explicit when there is a "bump in the road": an unexpected outcome, a breach in synchrony, a mistake, a rupture in a therapeutic relationship. The bump can (1) focus conscious attention on the therapeutic interpersonal process and (2) trigger reflective and integrative processes. That means that 'bumps' are useful to therapy. Addressing them can become a **critical cause of change.**

Bumps in the Road to Change

Bumps are discrepancies. For example:

1. **Not agreeing on what the real problem is:** Families need to present the problem as precisely and completely as possible. Therapists, however, shouldn't believe everything the family says. Both parties can perceive the other as not understanding what the real problem is.

2. **Feeling that the treatment is dangerous:** Families should refuse treatment that appears dangerous. Therapists should prevent danger even if the steps necessary to do so are distressing (such as remembering exactly what happened in the past). This can lead to disagreement about what to do.

3. **Feeling unseen by the therapist:** Families should refuse treatments that appear impersonal. Therapists, however, should build on the scientific and clinical knowledge base. This can result in disagreements about the fit of the treatment to family members.

4. **Engaging the treatment system:** Families should keep therapists interested, but not interfere with their work. Therapists should keep families committed, but not overly dependent. Finding this balance might lead to disagreement about how much treatment is needed.

5. **Identifying the 'truth':** Families should seek truthful information from therapists. Therapists should consider what form of the truth is compatible with family members' zones of proximal development. Sometimes families and therapists might play 'hide and seek', or be too vague to be understood or too explicit to be tolerated.

6. **Deciding what topics to address:** Families should manage information so that they feel safe (for example, keeping it in the forefront of awareness or at a distance from perception). Therapists should help families explore new ways of dealing with information (i.e., reversing the automatic highlighting or minimizing process). This might lead to clashes about setting aside or emphasizing certain information.

7. D**eciding how much treatment to offer:** Families should use resources parsimoniously and refuse treatment that is not needed. Therapists should not hurry when family members are not ready. There can be disagreements about how much and what kind of service to offer.

Professionals' Responsibilities

The professional's role in treatment might be conceptualized as: while carrying out explicitly agreed upon tasks in each family member's zone of proximal development, train oneself to perceive discrepancies, paying special attention to somatic and affective representations ("feeling" the ruptures). Use this perception to guide interpersonal communication so as to repair the rupture. By keeping this process visible and explicit, therapists can model a process for on-going adaptation for individuals and families.

Rodolfo De Bernart, MD
Psychiatrist, Systemic Family Therapist

Andrea Landini, MD
Child and Adolescent Psychiatrist, Cognitive Therapist