Introduction

Can anything be done to reduce the 'high risk' behaviour or characteristics of parents in the child protection arena?

What can therapeutic intervention mean in the context of social work assessment and practice?

How can the framework of the Dynamic Maturational Model of Attachment (also known as the DMM, Crittenden 2008) enable practitioners to understand the meaning of behaviour which is self-protective in the parents but potentially harmful to the child?

This poster focuses on a group of 'high risk' parents currently involved with the child protection system.

The parents are seen to be unable to protect their child from harm and to protect the child from their own emotional harm (common social work terminology: 'unable to prioritise the needs of their child above their own').

It is argued here that these parents, who would not normally access psychotherapeutic help with mental health issues, may be able to benefit from therapeutic interventions that focus on enhancing the attachment relationship between parent and child.

The Setting

The work described here took place in a voluntary sector organisation called Family Care based in Peterborough in the UK. This organisation undertook assessments of attachment and parenting for Local Authorities and the Courts. I was a social worker for a multidisciplinary team responsible for both undertaking assessments and carrying out parent-infant work. My training is in social work, although I also have training and experience in the delivery of psychoanalytic attachment approaches in families with infants and young children. In my work I drew on the ideas of Psychoanalytic Parent-Infant Psychotherapy (Baradan 2005), as well as the mentalising approaches as developed by Fonagy and others (Fonagy 2006). I was supervised in this work by a trained psychotherapist.

The Clients

Referrals came via the Local Authority and all families were the subject of ongoing court proceedings regarding the CARE of their child. They were commonly:

- Young, female (18-24)
- In unstable and/or abusive relationships
- Childhood experience of abuse/neglect
- Sometimes substance abuse or inclined to ‘binge’
- Unsupported by wider family and socially emotionally isolated
- Apparently compliant and co-operative but make ‘poor choices’ and seem resistant to change
- ‘Unable to prioritise child’s needs above own own’

Assessment Tools

All assessments involved taking a full history from the parents as well as:

- The Adult Attachment Interview (DMM-AAI, Crittenden 2007)
- The CARE-Index with the child/infant
- The Parent Development Interview (Aber et al. 2004)

Interviews and the CARE-Index screen were coded by independent and reliable coders in the measures.

Understanding Parents Using the Attachment Classifications of the DMM-AAI

The use of the Adult Attachment Interview, classified according to the Dynamic Maturational Model of Attachment (DMM), allowed us to understand the ways in which past experiences of danger had shaped the adult’s current functioning in close relationships.

The DMM highlights the ways in which information is distorted by the adult using the different attachment strategies in order to stay and feel safe. Of particular relevance to therapeutic intervention is the distinction made between Type A strategies that inhibit negative affect to place to, or support rejecting, punitive, or withdrawn caregivers (leading in extreme cases to the creation of a false positive self), and Type C strategies which exaggerate the negative affect to coerce others into behaving more predictably.

In addition, the DMM-AAI highlights areas of unresolved loss and trauma, and modifiers such as ‘depression’, which threaten to de-rate the parent’s strategy of feeling and staying safe in relationships.

Reflective Functioning

“A mother’s capacity to hold in her own mind a representation of her child as having feelings, desires and intentions allows the child to discover his own internal world, as per the mother’s representation of it.” (Slade 2005)

Reflective Functioning (RF) allows the parent to regulate their child’s emotional arousal and their own through an understanding of the mental states that lie behind the behaviour of both parent and child. Whilst most of the parents involved with the child protection agencies show lower levels of RF, assessment of the observed ‘face-to-face’ interaction can access therapeutic intervention, and the nature of intervention needed.

Connection to the Child

“Some children ... had an unacknowledged script or blueprint for their life that submerged their personal identity or personal characteristics, and this meant they came to dominate the parent-child relationship... The children became ‘actors in someone else’s play’.”

Reder and Duncan, 1999

The PDI also allowed us to formulate an understanding of how the parents’ experiences of trauma and danger (as understood by the DMM- AAIs) have influenced the way in which the parents view and about their relationships and their child parenting (Grey 2010).

This connection, or lack of it, is compared with an understanding of the attachment bond and its relationship between the parent and baby, through the classification of 3 minute clips of the parent and baby playing together according to the CARE-Index (Crittenden 2007). The CARE-Index also facilitates understanding of the infant’s contribution to the parent-child relationship.

“The primal importance of early parenthood may be to ‘beginning and end’ the separation-bonding circuitry’ can cause acute and possibly ongoing difficulties for parents and infants” (Raphael-Leff 2005)

Parent-Infant Therapy Perspectives

Although Parent-Infant Psychotherapy has its origins in a psychoanalytic perspective it has much to offer the practitioner who may utilise theories of attachment because:

- The focus is on the relationship between parent and baby rather than individual
- The therapist attends to the moment by moment interactions between parent and child
- Processes such as rupture and repair, and mirroring and attunement, are the focus
- A mentalising stance is modelled by the therapist which helps the parent make meaning from the infant’s communications
- Historical perspectives and unconscious processes are reflected upon and intergenerational paradigms acknowledged

Conclusions and Reflections

Listening to the needs of the parent

The largest group of ‘high risk’ parents referred to us had compulsively inhibited patterns of attachment (DMM classifications of A3-A7), with significant Unresolved Loss and Trauma.

These parents minimised their own emotional needs, and were cut off from their own negative feelings.

Most of these parents were said to be ‘unable to prioritise the needs of their child above their own’. However, they had very little awareness of what their own needs were.

Many were often ‘de-railed’ from good intentions, by behaviour they couldn’t understand or readily control, because it was the only way to ensure their child’s safety.

Case Study: Chloe and Amy

Chloe was 20 years old, having a daughter Amy, aged 10 months. Amy had been in foster care for two months because Chloe broke an agreement to restrict access to his daughter Terry. Chloe had experienced past violence in her relationship with Terry but seemed unable to sever contact with him or his extended family.

Chloe had early significant losses as both parents died of cancer when she was 4-5 years old. She was cared for by her half-sister who was a teenager herself. Chloe’s emotional needs were largely over-looked and she became increasingly self-reliant and socially promiscuous. She showed a pattern of attachment based on blaming herself and her feelings of anger and fear (which might harm Chloe as a warning her in dangerous relationships). As a result, Chloe minimised and exonerated Terry’s violence and abuse.

“What I just don’t no-one can do anything. People can punch you, people can beat you up, but in the end of the day your bruises are going to heal!”

When Amy was born, Chloe felt an emotional connection to her like no other. Her Care Index did raise concerns about unresponsiveness, these were not in the high risk range. However, Chloe appeared to be unable to renounce Terry without support and Amy showed signs of compulsive caregiving behaviour, which served to keep her mother ‘up’ and focused on her.

Therapeutic sessions explicitly explored Chloe’s need for comfort which, she felt, had only been met by Terry, making her vulnerable to Terry’s attempts to re-engage her. We also addressed Chloe’s feelings of self-responsibility and self-blame and her tendency to re-engage with someone (such as Terry and herself) to Amy. We focused on her connection with Amy and her ability to use Amy’s need for comfort and safety. At the same time we explored ways in which Chloe could more appropriately address and meet her own needs in ways that helped her be strong enough to meet Amy’s.

Addressing Systemic Obstacles to Change

Although presenting challenges in creating a safe space for change, the context of the work was also an opportunity to address how the child protection system perpetuated the difficulties of these parents.

Focusing on the problematic behaviour alone, professionals reinforced the parents’ strategy of self-blame, unintentionally making these parents more cut off from their own needs and difficulties, and more vulnerable to being blown off course by unmet needs and dismissed feelings.

Qaiser with other professionals was crucial to the process, helping professionals understand the meaning of ‘risks’ behaviour. Such incidences were frequently associated with self-correcting, and an attempt by the parent to reduce their own emotional arousal which was unacknowledged and threatening to them.

From Self-blame to Self-compassion

These parents often blamed themselves and experienced considerable shame regarding their own behaviour which they did not understand.

Encouraging self-compassion and self-understanding was crucial to the process allowing the parent to moderate their own behaviour and turn to others for help and support in new ways.

For additional information, please contact:

Kesteven
Family Assessment Partnership
Saloon Green Road,
Cambridge, CB1 6JZ
Tel: 01223 32 42 42
Fax: 0848 707 349
fap@attachmentrelationships.co.uk
www.attachmentrelationships.co.uk

References