Module #6: Attachment

Student Packet
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Overview

This module provides students with an understanding of trauma and attachment as they impact adopted children and their families. Students learn the processes of healthy and insecure attachment and the role of attunement in attachment. Through didactic presentations and experiential learning, students develop an understanding of Dyadic Developmental Psychotherapy as one approach to working clinically on attachment issues and they begin to develop clinical skills in utilizing this attachment-focused psychotherapy with adopted children and youth and their adoptive families. This Module provides students with opportunities to assess their readiness to do trauma-focused work with children, youth and families.

Learning Objectives:
Students will be able to:

1. Define “intersubjectivity” and describe the relationship between intersubjectivity and attachment.

2. Describe five components of Dyadic Developmental Psychotherapy (DDP) that are common to the empirically based psychotherapies and the four elements that comprise “PACE”.

3. Demonstrate the ability to find something to like in an adoptive parent even when the parent’s behavior in relation to the child is negative.

4. Give at least two examples of how a parent’s attachment history may impact his/her parenting of his/her adopted child.

5. Describe the role of adoptive parents in attachment-focused psychotherapy and two ways to prepare adoptive parents for the sessions with their child.

6. Identify at least three skills that the therapist uses in assessing the child in initial sessions.

7. List at least three principles of DDP.

8. Describe how a therapist uses playfulness and curiosity to engage the child and demonstrate the power of curiosity in therapy.

9. Describe three clinical skills that are essential to the therapeutic work of DDP.

10. Describe at least two other attachment-focused interventions in working with adopted children and youth.
Module #6: Attachment
Pre-Module Assignments

Student Assignment Checklist

- Read excerpts from two articles by Dr. Dan Hughes on Dyadic Developmental Psychotherapy (DDP). The excerpts are provided below.
- Review a powerpoint presentation on DDP.
- Write 2-3 paragraphs on how, based on what you now understand about DDP, you could incorporate the principles and/or practices of DDP into your work.
- Briefly review information on DDP training.

Student Assignments

Pre-Module Assignment #6.1: In our Module, we will primarily focus on dyadic developmental psychotherapy (DDP), an evidence-based treatment approach for the treatment of attachment disorder and reactive attachment disorder. Children who have experienced pervasive and extensive trauma, neglect, loss, and/or other dysregulating experiences can benefit from this treatment. Dyadic Developmental Psychotherapy is based on principles derived from attachment theory.

#6.1a: Prepare for class by reading the following excerpts from two articles by Dr. Hughes - The Development of DDP and Attachment Focused Treatment for Children (the entire article on attachment focused treatment for children is posted on the C.A.S.E. website if you are interested in reading it; a third article, An Attachment-Based Treatment of Maltreated Children and Young People, by Dr. Hughes is also posted on the C.A.S.E. website).

The Development of DDP by Dr. Dan Hughes

In this article, Dr. Hughes describes the work of others who greatly influenced his development of DDP. As you read the process he used to develop DDP, note the key themes that he identified and then developed into the DDP model.

In 1985 I was attempting to provide treatment for a 9-year-old foster girl who presented with many emotional, behavioral, and social difficulties. I had noticed that she had manifested similar difficulties in her previous three foster homes and that in each case, the problems did not become evident until she had been living in the home for about three months. I commented on that fact to her and asked her if she would want any help. She quickly replied that she did want help. Not hearing such a response very often, I replied with enthusiasm: “Great, what would you like help with?” Her response was deliberate and thoughtful: “Could you help me to move every three months?”

This girl’s request left me speechless. I struggled to understand her view of her world. What did “family” mean to her? What were her motives for such a request? Why did she not know what she was
missing? Most importantly of all, how could I help her to attain what I thought was in her best interests—a stable, permanent, home—when she saw value in attaining the opposite.

My clinical training did not prepare me for a girl who wanted to move to 30 or 40 foster homes before turning 18. In graduate school and during my clinical internship I had been exposed to psychodynamic, cognitive-behavioral, and family systems theories and their related therapeutic interventions. None of these seemed to explain this girl’s wish nor how I might have an impact on her wish and her subsequent development.

In 1986 I chanced to attend a workshop in Maine that was being given by a pediatrician by the name of Vera Fahlberg. She spoke with great enthusiasm about attachment theory and research. While I had previously heard about this theory I had never taken much interest in learning more about it and it had not been part of my graduate school education. (I had received my Ph.D. in Clinical Psychology in 1973.)

What she said sparked my interest in learning more and I turned to the literature. I was shocked to discover the depth and comprehensiveness of the research. This truly was not some fringe theory without research backing. It was evident that my lack of knowledge about attachment theory and research represented a giant gap in my training and knowledge. As I began to study however my irritation over what I did not know was quickly replaced by my excitement over what I was learning. I was beginning to understand why a 9-year-old girl might want to move every three months. I was beginning to understand what she had not experienced and what she did not understand: the meaning and value of a secure attachment.

For the next several years I learned about John Bowlby and Mary Ainsworth. I discovered the research of Alan Sroufe, Dante Chichetti, Mary Main and Patricia Crittenden, among others. I began to understand how abuse and neglect create a legacy that can greatly impair a young child’s ability to feel safe, to trust others, to enter into reciprocal, enjoyable interactions with attachment figures, to seek comfort and support under conditions of distress and to proceed along pathways that facilitate their overall psychological development. I began to understand why some children who had been exposed to intrafamilial trauma had such difficulty achieving resolution of the traumatic event while others did not. I was learning a great deal about attachment but was much slower to learn how to assist children who had been traumatized and whose attachment behaviors were contradictory and disorganized to proceed along healthy developmental paths. They seemed to be living with skilled foster parents but they were not able to permit their foster parents to “parent” them. And I was not of much assistance.

In 1989-90 two experiences helped me to begin to develop new ways of providing psychological treatment for foster and adopted children and their families. The first experience involved two visits to The Attachment Center in Evergreen, Colorado. This was the only program that I was aware of at the time that spoke of treating “reactive attachment disorder”. This program offered a form of treatment at that time that was quite controversial and was known as “holding therapy”. It involved adopting a much more active stance in treatment than I had ever considered. The stance involved providing high levels of
confrontation with regard to the children’s defenses and behaviors as well as high degree of nurturance for their traumatic roots and current fears.

The foster or adoptive parents were actively involved in the treatment and in providing a home structure that was congruent with the treatment itself.

My response to the treatment program at The Attachment Center was one of strong ambivalence. They were working with children who had severe emotional, behavioral, and social difficulties and I knew that the traditional approaches of treatment that were available to me would not be helpful for them. They were taking a very active stance and they were directly addressing the child’s past traumas and current difficulties. It immediately seemed to me that an active stance might be necessary since the more nondirective and play-centered approaches of treatment that I had been using were not effective. It also seemed that if I were able to sufficiently engage the child to successfully address the child’s traumatic experiences and current difficulties I might be able to help him or her to resolve and integrate these experiences into a more coherent sense of self. They also frequently found ways to assist the children in noticing the quality of care that they were receiving in their foster or adoptive home.

My response was ambivalent because I did not believe that the highly confrontational interventions could facilitate a sense of safety that I thought to be necessary if the child was to be open to exploring past traumas as well as new ways of relating with his or her foster/adoptive parents. I also did not believe that many of the interventions that I saw were congruent with the attachment theories and research that I had been studying for the previous 4 years. While I could see the value of a more directive, active stance that facilitated the child’s readiness and ability for greater emotional awareness, attachment behaviors, and communication skills, I did not concur with central features of the interventions that were being used.

My second experience served as the impetus for developing new interventions to achieve the goals just mentioned. I read The Interpersonal World of the Infant by Daniel Stern. This book made me aware of the moment-to-moment dyadic interactions between parent and young child that facilitates their attachment, the child’s emerging sense of self, as well as the development of associated emotional, social, cognitive, behavioral, and linguistic skills. I was able to see that the very active stance intuitively taken by parents is necessary for so many areas of their child’s development. I became entranced by the concepts of attunement, vitality affect, cross-modality matching, and intersubjectivity.

I could see how these parent-child experiences led to safety, attachment security, discovery of self and other, exploration of the world and an integrated sense of self. They represented the means whereby young children first acquire these skills.

... 

At about this time—1995—I discovered the comprehensive work of Allan Schore, Affect Regulation and the Origin of the Self. In his book Schore brought together an extensive body of research in the areas of neuropsychology, early childhood development, infant mental health and psychoanalytic
concepts. He covered both normal early childhood development and developmental variations that resulted from abuse and neglect. His theoretical formulations and conclusions from such a wide range of studies were truly remarkable.

One of Dr. Schore’s areas of focus that I found to be the most helpful for the treatment model that I was trying to develop was his consideration of the role of shame in early childhood neurological, emotional, cognitive, and social development. He demonstrated how, as the infant enters toddlerhood, she enters into a neuropsychological state of shame when limited by her parents. He shows how this is a normal aspect of early childhood and represents the first means of socialization of the young toddler. In normal parent-child relationships, the parent observes the distress of the state of shame caused by the limit, and quickly co-regulates the affect and repairs their relationship, while still limiting the behavior. The shame remains small and quickly dissipates, but it has an important role in activating states of inhibition and impulse control. However in homes characterized by abuse and neglect, the young child experiences “pervasive shame” that does not dissipate. The limit itself may well have been abusive, triggering overwhelming negative affect that could not be regulated. The parent was likely to also have abandoned the child in that state, not attempting to regulate the affect or repair the relationship. If a young child is holding an expensive camera and it is taken from him, his experience of shame will be small if the parent explains why it is being taken, comforts his distress, and helps him to direct his attention to something else. However, if the parent screams at the child, slaps him and then refuses to talk with or comfort him, that child is certain to enter into a deep, long-lasting state of shame that will be very difficult to regulate. That child will be at risk of not being able to explore well nor seek comfort when in distress. With repeated experiences of similar degrees of shame he is likely to conclude that he is stupid, bad, and/or unlovable and to hesitant to try to meet his most basic interpersonal needs.

This focus on pleasure and joy led me to the work of Colwyn Trevarthen regarding primary and secondary intersubjectivity. Trevarthen demonstrates in detail how the infant and young child develops the original sense of self, other, and the world through the affective/cognitive responses that their attachment figures have toward them and their world. Bringing these insights into therapy and parenting for abused/neglected children, one can see the need for the child to be able to have a positive impact on his therapist and foster/adoptive parents. Yet, this may be difficult when the child’s frequent misbehaviors and disorganized attachment behaviors may activate a negative response from the adults in his or her life. This dilemma is solved if the therapist and parents are able to persistently gaze upon and respond to “the child under the behaviors”. Rather than confusing the symptoms for the child, the therapist and parent need to be responding to the underlying motives, perceptions, thoughts and feelings that led to the behavior. Looking “under the behavior” they are likely to see fear and doubt, shame and discouragement, confusion and mistrust as well as courage, hope, and a deep desire to become attached to their parents and to feel worthy of such attachments.

Over the past five years I have become more aware of the powerful role of the parents’ own attachment histories on their ability to be able to help their child to resolve in their attachment
histories. Their child’s behaviors secondary to abuse, neglect or insecure/disorganized attachment behaviors often activated similar issues in the parents’ attachment histories. As a result, the parents were not able to remain regulated in the presence of their child’s behaviors and not able to help the child to create new meaning about a situation and modify his or her behavior. Thus, it became increasingly evident that the treatment had to include an exploration of the parents’ attachment histories and assistance in addressing any unresolved aspects. The research of Mary Dozier, Miriam Steele, and their colleagues makes this point very clearly.

As this process unfolds, I expect that the following factors will prove to be the “active ingredients” in this attachment-focused, narrative-making model of family therapy. These factors all facilitate the ability to develop and maintain a rhythmic emotional dialogue that enables the co-creation of coherent narratives for our clients.

1. Nonverbal-verbal communication. For toddlers verbal communication flows naturally from nonverbal communication. For all of us nonverbal communication is the primary means we have of giving expression to our inner lives as well as to become aware of the inner lives of others. The therapist needs to be sensitively aware of the nonverbal expressions of family members, help to make these expressions verbal, and help to create congruence between the nonverbal and verbal.

2. Follow-lead-follow. The therapist is not distracted by the nondirective/directive debate but rather follows the lead of the family member, joins, and when necessary leads into related areas that are being avoided, while then following the client’s response to that lead. This process parallels the parent-infant dance.

3. Connection-break-repair. In therapy, as in all relationships, there are frequent breaks in the felt-sense of connection do to many factors. The therapist notes the breaks, accepts them, understands them, and facilitates interactive repair. Breaks are not to be avoided but rather are utilized for their meaning and as the source of new change opportunities in the relationship and the self.

4. Affect/reflection balance and integration. Meaningful dialogue contains a blend of affect and cognition, conversation and reflection, which holds the interest of the participants and co-creates the meanings of the narratives. The therapist is aware of the affect/reflection components of the here-and-now expressions and facilitates their balance, congruence, and integration.

5. Attitude of playfulness, acceptance, curiosity and empathy. These factors provide the momentum for the therapeutic, transforming quality of the dialogue. The therapist actively conveys through these qualities that all memories, affective states, and
events can be accepted, understood, and integrated into the narrative. Breaks are easily repaired and the flow within nonverbal/verbal, affect/reflection, lead/follow proceeds within a sense of safety and with an openness to the discovery of new aspects of self and relationship.

6. Parent-child attachment classification congruence. The therapist works toward facilitating congruence between the parent and child with both moving toward security/autonomy. The lead in the movement is most often the parents, but this is not a linear process and the progress is reciprocal.

Other factors may also certainly be identified as being “active ingredients” in the effectiveness of the treatment. I believe however that they will not displace these six features, but will more than likely complement and enhance them.

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In this chapter, Dr. Hughes describes three key interventions of DDP. Think about how you might use these interventions in your clinical work.

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**PEARLS**

The following three interventions are based on these theories of attachment and intersubjectivity, both of which are central features in human development, being crucial for both safety and exploration.

**Pearl #1. Match or lead the expression of affect.**

When an adult matches a child’s nonverbal affective expression of his or her underlying emotion, the child often is able to experience the adult’s empathy for his or her experience and better regulate the underlying emotion. The adult’s affective communication of his or her experience of the child’s emerging experience enables the child to become aware of—and deepen—his or her own experience.

When children (and probably adults as well) give expression to their inner lives, they do so with an expression of affect that reflects both the information and energy that characterize the focus of their attention. The particular emotion associated with an event that they are describing is conveyed with a unique facial expression, voice prosody, and gestures and movements that best convey the particular meaning of that event for the child. The rhythm and intensity of the nonverbal expression conveys “how” and “how much” the event affected the child. When the adult matches that affective expression (often without feeling the child’s underlying emotion), the adult is able to convey that he or she “gets it,” and the child feels “felt.” In other words, the child experiences the adult’s experience of empathy for him or her in a way that words would never communicate alone. For example, if a child screams “I hate
my dad!” in a therapy module, and the therapist replies, with the same intensity and rhythm as the child’s expressions, “You are really angry with your dad right now!” the child is likely to feel that the therapist does “get” his experience. If, however, the therapist says “you are really angry with your dad right now” in a flat tone of voice, the child is not likely to experience the therapist as “getting it.”

Along with conveying empathy for the child’s experiences, matching the affect also helps the child to regulate his or her experience. When a child experiences intense anger, that expression of anger is demonstrated by an intense affective expression in his or her voice, face, and gestures. If the child does not experience a similar response from an adult, the intensity is likely to escalate, as the child may struggle to regulate the emotion. If the child lacks general affect-regulation skills, any increase in intensity only increases the risk of dysregulation. By matching the intensity and rhythm of the affective expression (and remaining regulated him- or herself), the adult is able to help the child to remain regulated. By finding the adult with him or her in the intense experience, and communicating with the adult about it, the child often finds him- or herself becoming less distressed and agitated.

Children may have trouble identifying an experience because it is new. They may be uncertain how to communicate it or worry that maybe they should not have it. This is especially true of children raised in circumstances where aspects of their inner lives are not seen or encouraged or when they have experienced traumatic events. In those situations, if a therapist is able to make sense of the child’s experience and take the lead in its nonverbal affective expression, the child is often able to experience it more deeply and communicate it more fully him- or herself.

**Pearl #2. Be Curious about the child’s inner life.**

When curiosity is directed toward the child’s experiences—rather than toward the factual events of his or her life—and when it is conveyed with both affective and reflective features, the child is likely to go with the therapist very deeply into his or her life’s story, coregulating any emotions that are associated with what is being explored and cocreating the meaning of the events.

Curiosity, used in this sense, is not a barren or intrusive exploration into the recent or remote past, but rather an act of discovery—an experience of fascination—with who this child is and how his or her life has unfolded, along with the impact of that history on his or her sense of self. The facts themselves are not as important as the meaning of these events on the child’s developing narrative. Through nonjudgmental, “not-knowing” curiosity, the therapist is often able to assist the child in deepening the experience of the event, along with reorganizing it and integrating it into his or her narrative. A word of caution: If the child experiences the adult’s interest as suggesting what he or she should have thought, felt, or wanted, the child is likely to begin losing interest in the process and may actively conceal his or her inner life from the adult.

For curiosity to go deeply into the child’s life story, it must contain not only a reflective but also an affective component. It must not be a detached, professional, observer’s interest, but rather the experience of someone who is truly deeply interested in the inner life of the other. While exploring the
child’s narrative, the therapist needs to be affected by what they are experiencing together through the act of discovery. In his or her wondering—his or her deep interest—the therapist is likely to express him- or herself in deeply affective manner, such as: “Wow! Do you think that maybe . . . ?!” or “Wait a second, wait a second . . . I wonder if . . . ?!” or “Yes, I think I get what you are saying! It’s like . . . !” or “So that’s what made it so hard for you! Now I get it, now I get it. You had always thought . . . !” The therapist’s enthusiasm for the process of discovery or his or her compassion and empathy for what they are discovering together helps the child to experience his or her inner life as being very important and meaningful, and the process of discovery as being safe. What the child thinks, feels, remembers, and makes sense of in his or her life is completely accepted by the therapist. Further, this joint exploration “touches” the therapist. What they discover together gradually elicits less shame or fear. The child now is much more able to begin to establish a coherent narrative.

Pearl #3. “Talk for” and “talk about” the child.

Children who manifest various psychological problems often have gaps in both their affective and reflective skills. They often have difficulty regulating, identifying, and communicating their inner lives to others. Giving them the safety to “find the words” can often be a slow and unproductive process—they truly do not “find” them. Utilizing metaphor to express their inner lives is often insufficient for empowering them to be able to integrate and communicate their narrative. Taking the lead in assisting them to give voice to the events of the past often also greatly assists them in organizing these events into a coherent narrative.

When a therapist “talks for” a child, he or she tries to replicate the child’s own speech and voice prosody and speaks in the first person as if he or she were the child. The therapist’s words are embedded in nonverbal affective expressions. The child is then able to “try out” the therapist’s expressions as if they were his or her own. The child often then makes use of the expressions that resonate with the wordless experience of his or her inner life, which frequently leads to a spontaneous elaboration of it, or a modification that best describes that unique experience. The therapist’s guesses that do not resonate with the child’s inner life tend to be quickly discarded and forgotten. Throughout this process the therapist is clear that when he or she speaks for the child, he or she is guessing what the child might want to say if he or she had the words. The therapist is clear that he or she always accepts the child’s statement as to whether or not the guess is accurate. If the child tells the therapist not to guess, the therapist always complies with those wishes. When the therapist is able to take the lead in finding the words to describe an experience of an event in the child’s life, frequently the child begins a process of being able to identify and communicate an aspect of his or her inner life that previously had been unknown, nameless, and often frightening and chaotic. This process also often leads the child to begin to deepen and integrate his or her emotional experience of the event. The nonverbal affective expressions of the therapist, associated with the verbal content, often lead the child into an emotional experience that is congruent with the expressed affect. We tend to forget that this same process occurs countless times in the intersubjective activities that exist between parent and infant.
“Talking about” a child is often a valuable complement to the affective meaning-making that is often facilitated by “talking for” a child. Talking about a child involves turning to his or her caregiver and reflecting something that just happened with the child, often connecting it to a deeper or more comprehensive aspect of the child’s narrative. This reflection always conveys a positive, accepting tone. This intervention can also be used by talking to a poster, stuffed animal, or even oneself by “thinking out loud” about the therapist’s experience of the child’s strengths and vulnerabilities. This process tends to lower the affective tone of the discussion and help the child to move into a calmer, more reflective stance. Such a stance enables the child to stay regulated while exploring stressful events from the past. It gives him or her a break from the affect generated by the explorations. At the same time, it enables the child to step back and reflect upon what he or she and the therapist (and possibly the parents or other significant people in his or her life) have just experienced together. During the affective exploration, the child experiences unique events in his or her narrative, and through the reflection the child is able to take a more distant and integrative perspective. When the therapist talks about the child rather than to him or her, the implied message is that the child does not have to respond, and he or she often more fully listens to what is being said without being distracted by having to prepare a response. Children also often more fully accept what is being said about them because they are less likely to experience the words as trying to influence them.

... CONCLUDING COMMENTS

As I discovered how intersubjective experiences with attachment figures propel the young child’s development of his or her inner life, I have become convinced that such experiences should be the central feature in the therapeutic alliance developed with the child. The more traditional therapeutic stance tended to create ambiguity in how children experienced their therapist’s experience of them. Such a stance valued providing safety for the children so that they could resolve distress and organize their inner life mostly on their own, without depending on the therapist to do it with them. Another intention of this stance was to facilitate the “transference” of the child’s implicit relational knowledge onto the therapist.

... The three interventions described in this chapter have all been very effective in facilitating the coregulation of affect and cocreation of new meanings that are the hallmark of effective therapy. Matched affective expression is often the starting point of intersubjective experience (described as attunement by Dan Stern and synrhythmia by Colwyn Trevarthen). Without losing this affective engagement, the therapist’s active, not-knowing, nonjudgmental curiosity leads the child into his or her inner life, where he or she can begin the process of addressing the many traumatic or confusing events of his or her life and developing them into integrative experiences that will evolve into a coherent narrative. Because many children lack sufficient reflective skills to take the lead in this process, the therapist must be ready to facilitate the flow of the affective/reflective conversation by offering to guess
about the child’s inner life. Such guesses constitute “talking for” the child, and later “talking about” the child, and these dialogues often enable the child to develop communication skills. These initiatives activate greater affective resonance within the dialogue than would occur if the therapist simply talked to the child. Such “talking for” communications become unnecessary as the child develops his or her own reflective and communication skills, spontaneously—and creatively—taking the lead in the process of weaving the tapestry of his or her inner life.

#6.1b: Review the powerpoint presentation, Attachment Focused Family Therapy: What is Dyadic Development Psychotherapy by Dr. Courtney Rennicke at: http://nysccc.org/wp-content/uploads/Rennicke.pdf [NOTE: Please copy and paste the link into your browser to access this document]

This powerpoint presentation graphically summarizes the key components of DDP and provides a good summary of DDP.

#6.1c: Write two or three paragraphs responding to the question, Based on what you now know about DDP, how would incorporate its principles and/or practices into your clinical work? Provide your essay to your teacher and bring a copy of your essay with you to class.

#6.1d: Briefly review the following materials on DDP.

What is each Session of DDP like? Each of Dr. Hughes’ Modules is between 1.5 and 2 hours. The first 10-30 minutes are checking in with the parents only. The remainder of the time is with the child and parents.

How much time is typically required for DDP? The minimum of time in therapy is 6 months to one year. Therapy requires the commitment of parents and the funding source. Dr. Hughes says that when a child is with the right adoptive family, the chances are that the child will respond quickly – anywhere from 6 weeks to 9 months. It is not possible, however, to predict the child’s response.

Will every therapist be able or even want to do DDP? Not every therapist can or will do attachment focused therapy with children and teens who have experienced trauma.

Here are some guidelines for therapists who do this work:

• They must be able to work with children AND adults.
• Some therapists are not comfortable with their own attachment histories. Supervision is extremely helpful. A supervisor, for example, might ask, “So, you felt angry when the child walked out on you. Where did your anger come from?”
• The therapist must be comfortable working in front of participant observers: the parents. She must be relaxed in this setting, able to deal with shame when she makes a mistake. She must be able to model: to apologize and say, “let’s start over.”
• The therapist must be able to blend directive and non-directive approaches. Some therapists see distance as therapeutic. In attachment focused therapy, the therapist must overcome this view: the child has never had a relationship with value and meaning and be a “real person” with the child.

• Some therapists avoid trauma. The therapist may try to talk the child out of the pain or quickly reassure the child, rather than helping the child resolve the pain. The therapist may need to ask herself, “Why can’t I allow the child to talk about trauma? Why is it so hard to be with this child’s sadness and pain?”

• The therapist must be able to join in the child’s experience of traumatic events without joining in the event itself. For example, when a child has been sexually abused, the child may be aware of feeling some warmth and security. The therapist must not inject herself into the event, for example, by expressing disgust at the abuse. To express that disgust communicates disgust at the child’s sense of warmth and security.

**Where can I be trained in DDP?** Training in DDP is available through Dr. Hughes’ certification program. The training consists of:

• Beginning Level (4 days) and Intermediate Level (4 days). Training of 56 hours. The cost for each level is $475 plus $100 per hour of review of tapes.

• 100 hours of using the model

• 10 of the 100 hours of work is on video with feedback from Dr. Hughes or a certified DDP consultants

Information on the training can be found at: [http://www.danielhughes.org/](http://www.danielhughes.org/)
Module #6. Attachment

Agenda

9:00AM – 9:15AM Welcome
9:15AM – 10:00AM Introduction and Intersubjectivity
10:00AM – 10:20AM Introduction to Dyadic Developmental Psychotherapy (DDP)
10:20AM – 10:35M Break
10:35AM – 10:50AM Safety, Intersubjectivity and PACE
10:50AM – 12:00PM DDP: Initial Meetings with Parents
12:00PM – 1:00PM Lunch
1:00PM – 2:00PM Assessment of the Child or Youth
2:00PM – 3:30PM Attachment-Focused Psychotherapy with Children and Youth and their Families

   [a break will be called during this segment]

3:30PM – 4:15PM Other Attachment-Focused Interventions
4:15PM –4:30PM Summary and Closing
Reading List

Web-based Resources


Other Resources


Module #6: Attachment

Handouts
Handout #6.1  Core Components of Dyadic Developmental Psychotherapy

The following features of DDP are common to central components of much empirically-based psychotherapy:

1. **Therapeutic Relationship:** (Primary non-specific factor in most effective psychotherapies)

2. **Empathy:** Central factor in relationship development and maintenance

3. **Acceptance:** Increasingly emphasized relationship trait

4. **Curiosity:** Central in psychodynamic, narrative, person-centered.

5. **Gradual Exposure:** within A/R Dialogue: co-regulation of affect, co-creation of meaning

6. **Self-Soothing:** co-regulation of affect, breathing, sensate-focusing

7. **Coping Skills:** practice, self-talk, identifying attributions, narrative development

8. **Emotional Processing:** A-R Dialogue, matched and leading affect

9. **Communication Skills:** Expression of experience through practice, coaching, role-playing

10. **Social Skills:** Nonverbal communication; social cues for attributions

11. **Parent Consultation:** Active listening, safety, matched affect, discipline with empathy, success/strength focused, structure and supervision.

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Handout #6.2  DDT INITIAL EXPERIMENTAL STUDIES


1. In the first study, 34 Ss in treatment group (DDP) and 30 Ss in control group (standard community treatment—CBT, Play Therapy, Behavioral Management within home.) All foster/adopted children ages 5-16 years at treatment onset. 5/6 of both groups had prior treatment.

Results:

- On CBCL, no significant difference on pre-treatment testing between treatment and control groups.
- One year after termination of treatment, a post-treatment measure on CBCL is obtained.
- In treatment group, significant improvement on CBCL syndromes: withdrawn, anxious/depressed, social problems, thought problems, attention problems, rule-breaking behavior, aggressive behavior.
- In control group, no significant differences between pre- and post-treatment measurements on any CBCL scale.

2. In the second study, same original group. Contact made with 24 Ss from treatment group and 20 Ss from control group. Four years after termination of treatment, a post-treatment measure of CBCL is obtained.

Results:

- In treatment group, significant improvement on CBCL syndromes: withdrawn, anxious/depressed, social problems, thought problems, attention problems, rule-breaking behavior, aggressive behavior.
- In control group: no significant differences in withdrawn, social problems, thought problems. Significant worsening in anxious/depressed, attention problems, rule-breaking behavior, aggressive behavior.
<table>
<thead>
<tr>
<th>PACE stands for:</th>
<th>What it means</th>
<th>How it would be utilized in attachment-focused therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting</td>
<td></td>
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<tr>
<td>Curious</td>
<td></td>
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<tr>
<td>Empathetic</td>
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</table>
Handout #6.4  ASSESSMENT

Topics to Explore:

**History**-abuse, neglect, placements, attachments.

**Present Symptoms**

**Physical**-eat, sleep, pain threshold, boundaries, sensory-motor, language

Nonverbal communication.

**Affect**-identification, regulation, expression, range of positive & negative.

(excitement, joy, affection, terror, shame, rage, despair, intensity/duration)

**Behavior**-impulsive, reactive, submissive, passive, exploration, assertiveness

**Cognitive**-negative attributions, reflective functioning, desires-intentions,

Reciprocity, taking other’s perspective, cause-effect, nameless

**Parental functioning**

Own attachment history

Presence of attitude of acceptance, curiosity, empathy, playfulness

Child’s behaviors as triggers to own attachment history?

“Burned out” resentful, dejected/persistent, committed?

Personalize child’s behavior?

Child’s problem, not their problem?

Need child to make them happy?

Reject aspects of child?

**Therapist’s Observations**

Child’s interactions with me differ from interactions with parents?

When alone with me or when with me and parents together.

**Nonverbal communication**

Eye contact
Facial expressions

Gestures/Posture

Touch

Humor

Empathy

**Inner State:** access to affective life

regulation of affect/cognition/behavior

accepts co-regulation of affect, co-creation of meaning

**Inner State Communication:** ability to regulate

**Attunement—Shame—Interactive Repair**

**Motivation/Hopefulness:** Hope in parents; hope in child; belief in change

**Overall response to Module:** affect/cognition/behavior/interpersonal

**Affect:** what was the affect: intense, labile, none; where the parent and child were in sync

**Cognition:** reflecting behavior

**Behavior:** what behavior was like: calm, withdrawn, threatening, explosive; child screamed and threw things and had to be held; assess what was behind the behavior

**Interpersonal:** Between parent and child, between child and therapist, between parents and therapist

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**Handout #6.5 Parenting Profile for Developing Attachment©**

Respond from 1-5.  1 represents very little; 5 a great deal of the characteristic/skill.

Focus on adult’s abilities, not whether or not the child is receptive to the interaction.

<table>
<thead>
<tr>
<th>My Perception My Perception of</th>
<th>Of Self</th>
<th>Spouse/Friend</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________________</td>
<td>_________</td>
<td>_______________</td>
</tr>
<tr>
<td>1. Able to maintain a sense of humor-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>2. Comfortable with giving physical affection-</td>
<td>______</td>
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<tr>
<td>3. Comfortable receiving physical affection-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>4. Ready to comfort child in distress-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>5. Able to be playful with child-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>6. Ready to listen to child’s thoughts and feelings-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>7. Able to be calm and relaxed much of the time.-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>8. Patient with child’s mistakes-</td>
<td>______</td>
<td>______</td>
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<tr>
<td>9. Patient with child’s misbehaviors-</td>
<td>______</td>
<td>______</td>
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<tr>
<td>10. Patient with child’s anger and defiance-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>11. Patient with child’s primary two symptoms-</td>
<td>______</td>
<td>______</td>
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<tr>
<td>12. Comfortable expressing love for child-</td>
<td>______</td>
<td>______</td>
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<tr>
<td>13. Able to show empathy for child’s distress-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>14. Able to show empathy for child’s anger-</td>
<td>______</td>
<td>______</td>
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<tr>
<td>15. Able to set limits, with empathy, not anger-</td>
<td>______</td>
<td>______</td>
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<tr>
<td>16. Able to give consequence, regardless of his response-</td>
<td>______</td>
<td>______</td>
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<tr>
<td>17. Able and willing to give child much supervision.-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>18. Able and willing to give child much “mom-time”.-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>19. Able to express anger in a quick, to the point, manner.-</td>
<td>______</td>
<td>______</td>
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<tr>
<td>20. Able to “get over it” quickly after conflict with child.-</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>21. Able to allow child to accept consequence of choice.-</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>
22. Able to accept, though not necessarily agree with,
the thoughts and feelings of your child.

23. Able to accept, though you may still discipline,
the behavior of your child.

24. Able to receive support from other adults
in raising this difficult child.

25. Able to acknowledge failings and mistakes
in raising this difficult child.

26. Able to ask for help from people you trust

27. Able to refrain from allowing your child’s
problems to become your problems.

28. Able to cope with criticism from other adults
about how you raise your child.

29. Able to avoid experiencing shame and rage over
your failures to help your child.

30. Able to remain focused on the long-term goals.

Dan Hughes
Handout #6.6  Case Examples

Case #1. Pamela’s mother was frequently ill and not able to care for Pamela and her older brother Nick. From infancy, her parents brought in a variety of babysitters to care for them. Pamela’s dad attempted to keep everything going but was exhausted from long working hours and his efforts to manage things at home. Pamela spent most of her time as a child alone, reading, listening to music, and writing poetry. Her brother Nick, six years older, left for the seminary when he was 16. He became a priest and has been working in Africa for the past 8 years. As a single adoptive mom, Pam adopted Francine, age 8, from foster care. She is struggling to understand her daughter’s aloofness and apparent inability to enjoy anything. Pamela is feeling increasingly depressed and lacking in energy to parent.

Case #2. Sandra and Jennie adopted four-year-old Benjie from foster care and were told that their son had lived with his mother and father since infancy. Benjie, now age 5, is a sweet child who also seems to be afraid of everything. He clings and whines in every social situation—whether it is walking down the street or going to the park or attending church. Jennie is feeling very tired of this behavior and has begun to push Benjie away while telling him to stop acting like a baby. When asked about her own childhood, Jennie shares that she grew up in a home where everyone pretty much fend for themselves. She was not close to her parents and they seemed to be happy with everyone staying at arm’s length.
Handout #6.7  Questions for Parental Self-Reflection


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1. What was it like growing up? Who was in your family?

2. How did you get along with your parents early in your childhood?
   How did your relationship evolve throughout your youth and into the present?

3. How did your relationship with your mother and father differ? Were similar?
   Are there ways in which you try to be like/not like each parent?

4. Did you feel rejected or threatened by your parents?
   Where there other experiences in your life that were overwhelming/traumatic?
   Are these experiences “still alive”? Continue to influence your life?

5. How did your parents discipline you? What impact did that have on your childhood?
   How does it impact your role as a parent now?

6. Do you recall your earliest separations from your parents? What was it like?
   Did you ever have prolonged separations from your parents?

7. Did anyone significant in your life die during your childhood or later?
   What was it like for you then and how does it affect you now?

8. How did your parents communicate with you when you were happy/excited?
   How did they communicate when you were unhappy/distressed?
   Did your father and mother respond differently during these times? How?

9. Was there anyone besides your parents who took care of you?
   What was that relationship like for you? What happened to them?

10. If you had difficult times during your childhood, were there positive relationships in or outside your home that you could depend on? How did those connections benefit you then and how might they help you now?
You meet with Yvonne, the adoptive mother of Michael, age 12. Her husband, Frank, does not come to the meeting. Yvonne appears to be very controlled, expressing little emotion. Suddenly, after about 30 minutes, she angrily blurts out, “I hate him [her adoptive son]! I just can’t stand to go on pretending to love him!” She sobs uncontrollably for several minutes then quiets. She returns to a calm state and says that she did not mean what she said. She continues to maintain that she did not mean these statements. You meet with her twice more and she continues to maintain a calm demeanor. You then meet with her and Michael.

*Scenario #1:* Michael states that he has no intention of cooperating. Yvnone, ignoring you, tries to wheedle Michael into talking. He snaps, “Shut up!” Yvonne grows red in the face and then begins to scream, “I hate you! I hate you!”

*Scenario #2:* Some situation. When Michael snaps, “Shut up!”, Yvonne begins to cry and says, “You don’t love me. You never did. Why did I think you would?”
Handout #6.9

DEVELOPMENTAL TRAUMA DISORDER
Toward a rational diagnosis for children with complex trauma histories
Bessel van der Kolk, MD
Psychiatric Annals 35:5 May 2005, Pp.401-408

“Traumatized children rarely discuss their fears and traumas spontaneously. They also have little insight into the relationship between what they do, what they feel, and what has happened to them.” P.405

“The PTSD diagnosis does not capture the developmental effects of childhood trauma:

- The complex disruptions of affect regulation;
- The disturbed attachment patterns;
- The rapid behavioral regressions and shifts in emotional states;
- The loss of autonomous strivings;
- The aggressive behavior against self and others;
- The failure to achieve developmental competencies;
- The loss of bodily regulation in the areas of sleep, food, and self-care;
- The altered schemas of the world;
- The anticipatory behavior and trauma expectations;
- The multiple somatic problems, form gastrointestinal distress to headaches;
- The apparent lack of awareness of danger and resulting self endangering behaviors;
- The self-hatred and self-blame;
- The chronic feelings of ineffectiveness.” P. 406

Treatment Implications “Treatment must focus on three primary areas:

1. Establishing safety and competencies.
2. Dealing with traumatic re-enactments
3. Integration and mastery of the body and mind.” P. 407

“Unless this tendency to repeat the trauma is recognized, the response of the environment is likely to replay the original traumatizing, abusive, but familiar, relationships. Because these children are prone to experience anything novel, including rules and other protective interventions as punishments, they tend to regard teachers and therapists who try to establish safety as perpetrators.” Pp.407-408.

Developmental Trauma Disorder

A. Exposure
--Multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma (eg. Abandonment, betrayal, physical assaults, sexual assaults, threats to bodily integrity, coercive practices, emotional
abuse, witnessing violence and death).

--Subjective experience (eg. rage, betrayal, fear, resignation, defeat, shame).

B. Triggered pattern of repeated dysregulation in response to trauma cues

Dysregulation (high or low) in presence of cues. Changes persist and do not return to baseline; not reduced in intensity by consciousness awareness.

--Affective

--Somatic (physiological, motoric, medical).

--Behavioral (eg. Re-enactment, cutting).

--Cognitive (eg. Thinking that it is happening again, confusion, dissociation, depersonalization).

--Relational (eg. Clinging, oppositional, distrustful, compliant).

--Self-attributional (eg. Self-hate, blame).

C. Persistently altered Attributions and Expectations

--Negative self-attributions.

--Distrust of protective caretaker.

--Loss of expectancy of protection by others.

--Loss of trust in social agencies to protect.

--Lack of recourse to social justice/retribution.

--Inevitability of future victimization.

Functional Impairment

--Educational

--Familial

--Peer

--Legal

--Vocational
Handout #6.10  AFFECTIVE/REFLECTIVE (A/R) DIALOGUE

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Child: “You don’t really care!!”

____________________________
Clarify, Elaborate, Explore His Subjective Experience:

Empathy: If you think that I don’t care, that must be hard for you!
Empathy: I feel sad that you experience me as not caring.
Associated feelings: How does it feel to be with someone you don’t think cares?
Associated thoughts: If I don’t care for you, why do you think I don’t?
Implications: What does it mean if I don’t care?
Coping strategies: How do you handle it, talking with someone you don’t think cares?
General coping: What do you do when you think someone doesn’t care for you?
Patterns: Do you have that experience with someone in your family/friend?
Self-worth: If you think I don’t care, does it effect what you think about yourself?
Assessment Experiences: Are there other times when you have the same thoughts about yourself?
Here & Now: How does it feel now talking with me when you think I don’t care.
I-Messages: I do care for you, but am not communicating it well or you would sense it.
I am so glad that you told me that you think that I don’t care.
I worry that therapy won’t be of help to you if you think that I don’t care.

Similar dialogues can occur for:

• This is stupid.
• I think I’m bad!
• I don’t care!
• I don’t want to talk about it!
• You/she never lets me!
• You just want me to be unhappy!
• You/he is mean to me.
• I don’t know.
• You/she thinks I’m bad.
• Just leave me alone.
• You/he make me so mad!
Handout #6.11 CORE ASSUMPTIONS ABOUT BEHAVIORS

Child’s Behaviors

Argue, complain, control, rage, withdraw, not ask for help, not show affection, bang head to sleep, scream over routine frustrations, constant chatter, avoid eye contact, lie, steal, gorge food, socialize indiscriminately

Under the Behavior

- Conviction that only self can/will meet own needs
- Never feeling safe
- Pervasive sense of shame
- Conviction of hopelessness and helplessness
- Fear of being vulnerable/dependent
- Fear of rejection
- Inability to self-regulate intense affect—positive or negative.
- Inability to co-regulate affect—positive or negative.
- Felt sense that life is too hard. Feeling “invisible”
- Assumptions that parents’ motives/intentions are negative
- Lack of confidence in own abilities
- Lack of confidence that parent will comfort/assist during hard times.
- Inability to understand why s/he does things.
- Need to deny inner life because of overwhelming affect that exists there.
- Inability to express inner life even if he wanted to.
- Fear of failure
- Fear of trusting happiness
- Routine family life is full of associations to first family
- Discipline is experienced as abuse/neglect
- Inability to be comforted when disciplined/hurt.

Parents’ Behaviors

Chronic anger, harsh discipline, power struggles, not ask for help, not show affection, difficulty sleeping, appetite problems, ignoring child, remaining isolated from child, reacting with rage & impulsiveness, lack of empathy for child, marital conflicts, withdrawal from relatives and friends, chronic criticism.

Under the Behavior

- Desire to help child to develop well.
- Love and commitment for child.
- Desire to be a good parent.
- Uncertainty about how to best meet child’s needs.
- Lack of confidence in ability to meet child’s needs.
- Specific failures with child associated with more pervasive doubts about self.
- Pervasive sense of shame as a parent.
- Conviction of helplessness and hopelessness.
- Fear of being vulnerable/being hurt by child.
- Fear of rejection by child as a parent.
- Fear of failure as a parent.
- Inability to understand why child does things.
- Inability to understand why self reacts to child.
- Association of child’s functioning with aspects of own attachment history.
- Feeling lack of support and understanding from other adults.
- Felt sense that life is too hard.
- Assumptions that child’s motives/intentions are negative.
- Feeling that there are no other options besides the behavior tried.

Dan Hughes
Handout #6.12

For Young Children

Attachment and Biobehavioral Catch-up (ABC)

Type of Maltreatment: Physical Neglect
Target Population: Foster parents of infants.

ABC targets several key issues that have been identified as problematic among children who have experienced early maltreatment and/or disruptions in care. These young children often behave in ways that push caregivers away. The first intervention component helps caregivers to re-interpret children's behavioral signals so that they provide nurturance even when it is not elicited. Nurturance does not come naturally to many caregivers, but children who have experienced early adversity especially need nurturing care. Thus, the second intervention component helps caregivers provide nurturing care even if it does not come naturally. Third, many children who have experienced early adversity are dysregulated behaviorally and biologically. The third intervention component helps caregivers provide a responsive, predictable environment that enhances young children's behavioral and regulatory capabilities.

Parent-Child Interaction Therapy (PCIT)

Types of Maltreatment: Physical Abuse; Emotional Abuse
Target Population: Children ages 3-6 with behavior and parent-child relationship problems. May be conducted with parents, foster parents, or other caretakers. Adaptation available for physically abusive parents with children ages 4-12.

PCIT was developed for families with young children experiencing behavioral and emotional problems. Therapists coach parents during interactions with their child to teach new parenting skills. These skills are designed to strengthen the parent-child bond; decrease harsh and ineffective discipline control tactics; improve child social skills and cooperation; and reduce child negative or maladaptive behaviors. PCIT is a treatment for disruptive behavior in children and is a recommended treatment for physically abusive parents.

Adolescents

Attachment-Based Family Therapy (ABFT) is based on the belief that strong relationships within families can buffer against the risk of adolescent depression or suicide and help in the recovery process. ABFT is a psychotherapeutic model, with a foundation in attachment theory. Attachment theory posits that when parents are responsive and protective, children develop a
healthy sense of self, trust in others, and better capacity for independence and affect regulation. Ruptures in attachment security can increase the risk for psychopathology. However, as a life-span developmental model, attachment theory posits that attachment ruptures are reparable, and thus children can regain the external and internal resources to promote healthy development.

**Target Population:** Depressed adolescents and their families

The ABFT model aims to strengthen or rebuild secure parent-child relationships and promote adolescent autonomy. To accomplish this, the therapist helps the family agree to focus on relationship repair as the initial goal of therapy. Then, with the adolescent alone, the therapist helps the adolescent identify perceived attachment ruptures or negative family processes and prepares the adolescent to talk about these problems with his or her parents. In separate Modules with parents, the therapist focuses on reducing parental distress and improving parenting practices. Exploring their own history of attachment rupture helps parents understand their own attachment wounds and builds empathy for the adolescent. When ready, conjoint Modules focus on helping the family successfully discuss these past problems. This process both helps resolve actual problems in the family and allows parents and adolescents to practice new skills related to affect regulation and interpersonal problem solving. As trust begins to reemerge, therapy focuses on promoting adolescent competency outside the home.
Handout #6.13  Attachment and Biobehavioral CatchUp (ABC) Case Examples

1. What have these children’s experiences been with:
   - Early inadequate care
   - Disruption in primary attachment relationships

2. How might these children benefit from ABC’s goals of helping parents:
   - Provide nurturance even when children do not appear to need it.
   - Provide nurturance even when it does not come naturally to parents.
   - Provide a very predictable environment, so the children can learn to regulate their behavior and emotions.

Esther. Esther was just 2 months old when she was taken from her birth mother and placed in a foster home where there were three other children. Her foster mother makes sure Esther is clean, clothed, and fed, but her other children and the sewing she takes in to help pay the bills leave her little time to interact with the new baby. Although she finds Esther’s quietness a bit strange, she has to admit to a certain relief that the child’s complacency and lack of fussiness mean fewer demands on her limited time.

Clarence. Clarence’s new foster mother is delighted to find herself with a 16-month-old now that her own babies are grown. At first, the baby doesn’t respond to the mother’s cooing and cuddling, pushing her away at times. Over time, however, her loving attempts are rewarded with his looking to her when he is upset. He even begins to call out “Mama” when a stranger enters the house, and moves quickly to her side. To her surprise, she finds that she wants to adopt Clarence. Over the next 2 years, Clarence’s paternal grandmother comes into the picture and seeks custody. As Clarence goes for overnight visits with the grandmother, his foster mother feels a panic over losing him that she had never before known. Eventually, when Clarence is 4, the grandmother recedes into the background, and he is adopted by his foster mother.
Karla was a 16-year-old African American girl who had lived with her mother and three young siblings before she entered foster care. Her parents’ rights were terminated when she was 12 and Julie and Sally Brown adopted her at age 14. After initially doing well in school, she is now doing poorly in the 11th grade. Karla came to ABFT with a severe episode of major depression triggered by the birth mother’s contacting her and telling her that her father had been killed while in prison. Julie and Sally are angry that the birth mother called with this information and believe that Karla should not have to be told any additional painful information about her birth family. Karla refuses to discuss her father’s death with them.

In the first Module, Karla remained quite and reticent to talk. Julie and Sally told of Karla’s depression and her current school problems over the years and their own struggles in accepting Karla’s birth family. They want to protect her from them. Karla became visibly angry. The therapists tried to explore these feelings, but Karla resisted these questions, even though Karla’s feelings about her birth family appeared to be quite intense. But rather than pursue this topic, the therapist used the relational reframe to address a bigger issue. “Why is it Karla, that when you have strong feelings like this, you cannot share them with your mothers?” Karla’s limited responses indicated that she believed she could take care of herself (“I have done it all my life”) and that they had enough to worry about with their jobs and managing all the other problems in their lives.

The therapist then turned to Julie and Sally and said, “It seems that your daughter is very protective of you, but unfortunately it leaves her feeling isolated and leaves both of you feeling left out of her life. Would you like to change this and become a better resource or even friend to your daughter?” Sally and Julie whole heartily agreed to this goal, but Karla remained skeptical. The therapist respected this resistance and just invited Kara to come alone next week to discuss her concerns.

The alliance session alone with Karla began with some general conversation about friends and school. The heart of the Session focused on understanding Karla’s feeling about her father’s death and her unwillingness to talk with her moms about it. Karla reports that she is quite used to taking care of herself and that she doesn’t want her moms to know about her dad as they do not approve of him anyway. She confides that she had witnessed several physically abusive episodes in her family prior to her father’s incarceration. She does not want her moms to know about this. Her therapists empathized with her protectiveness and her loneliness, but challenged her low entitlement to address her feelings about her father’s death. “Why don’t you deserve to express yourself, to have a voice? We think your moms are desperate to know you better and would want to know how you are feeling. After an hour of empathy and challenge, respect and encouragement, Karla still resisted the idea of a discussion with her moms but she did agree to attend the next family Session to hear what her moms might have to say after the therapists spoke with her.

In the meeting alone with Julie and Sally, the therapists developed a better understanding of their relationship, their decision to adopt, how the family had developed since Karla joined their family, and their feelings and concerns about Karla’s birth parents. As they discussed these issues, they began to
see how hard it must be for Karla knowing their disapproval of her birth parents and their desire to dismiss them completely from Karla’s and their family’s life. They began to understand why Karla was so depressed. Balancing confidentiality with setting up dialogue, we agreed that this was an important topic to address in the future conjoint Module. The session then turned to preparing Julie and Sally with a few listening skills (emotional coaching) that would reduce Karla’s barriers to expressing her feelings. The therapists also suggested that since Karla was a bit reluctant to speak up, that maybe they could start out talking about their thoughts and feelings.

In the fourth Module, the therapists brought Karla and her moms back together. The therapist opened the session with the following statement: “Clearly this family has many strengths and a lot of love for each other. But you are going through some challenging times that you have not been able to discuss together. But everyone has agreed to begin this conversation today.” The therapist then turned to Julie and Sally to begin, but Karla spoke up and talked for the next twenty minutes about her father and shared some good memories of him but also memories of when he had beaten her mother. Julie and Sally listened with sadness, shame, and anger but they did not let these feelings overwhelm them. Instead, they focused on her daughter, asking questions, showing curiosity, and expressing empathy. Once Karla had finished an uninterrupted story, her moms talked about their love for her and their desire to protect her from the pain of the past, but their recognition that they needed to take Karla’s lead on what worked best for her. Julie said, “We want you to be safe and happy and to be able to turn to us for help and love.” Karla, Julie and Sally began to cry and continued to talk about the past and the future.

In the following sessions, Karla and her moms shared that Karla had been coming to their room each night for long talks in bed. Julie and Sally renewed their advocacy efforts at school and helped Karla change some classes and arranged for extra tutoring. Karla’s depression diminished, but she still had bouts of moodiness and irritability. At a 6-month follow up, she reported no depression.