Module #6: Attachment

Teaching Script

Acknowledgement: The Center for Adoption Support and Education thanks Dr. Dan Hughes for his assistance in the development of this Module.
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Module #6 Attachment

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.

Materials Needed:

- LCD Projector and Screen
- Agenda
- Copy of PowerPoint Slides

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- Videos from Dr. Dan Hughes: Part 2: Children; Part 3: Parents (provided by C.A.S.E.)
- A hat/bag/basket
- Handouts:
  - Handout #6.1: Core Components of DDP
  - Handout #6.2: DDT Initial Experimental Studies
  - Handout #6.3: DDP and PACE
  - Handout #6.4: Assessment
  - Handout #6.5: Parenting Profile for Developing Attachment
  - Handout #6.6: Case Examples
  - Handout #6.7: Questions for Parental Self-Reflection
  - Handout #6.8: Yvonne and Michael
  - Handout #6.9: Developmental Trauma Disorder
  - Handout #6.10: Affective/Reflective Dialogue
  - Handout #6.11: Core Assumptions about Behavior
  - Handout #6.12: Attachment-Focused Interventions
  - Handout #6.13: Attachment and Biobehavioral CatchUp (ABC) Case Examples
  - Handout #6.14: Attachment Based Family Therapy: Karla
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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.

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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.


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 session, 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 is 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.

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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.

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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.


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/)
Pre-Module Assignments: Checklist for Teachers

Student are to:

✓ Read excerpts from two articles by Dr. Dan Hughes on Dyadic Developmental Psychotherapy (DDP) which are provided in their student packets. The entire article on attachment focused treatment for children is posted on the C.A.S.E. website. Also posted is the article by Dr. Hughes, *Attachment Based Treatment of Maltreated Children and Young People*.

✓ Review a powerpoint presentation on DDP from Dr. Courtney Rennicke.

✓ Write 2-3 paragraphs on how, based on what they understand about DDP, how they would incorporate the principles and/or practices into their clinical work. These essays are to be provided to you.

✓ Briefly review information on DDP training which is provided in their student packet.
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
Module #6. Attachment

9:00AM – 9:15AM  Welcome

Welcome back! Our Module today focuses on attachment. Before we begin class, count off numbers. Now, change seats in the order of the numbers that you counted off.

Allow time for seat changing and inevitable comments about having to do this. Ask:

- How does it feel to have to move to another seat?
- How attached were you to your first seat?
- What can you take from this fairly minor experience about the power of attachment in our lives?

We will spend this entire Module on attachment and working with children and young people and their adoptive parents on attachment issues.

First, let’s briefly review what we have covered before this class -- a range of clinical issues that you may encounter in your work with adopted individuals, adoptive families and birth families. We explored the new research on brain development. Have you experienced any of these issues in your work since our last Module together?

9:15AM -- 10:00AM  Introduction and Intersubjectivity

Lecture

In our Module today, we will work on the assessment of attachment issues and clinically treating children who have experienced trauma and are insecurely attached. As you know from your pre-Module reading, the principal intervention we will study is the Dyadic Developmental Psychotherapy model developed by Dr. Dan Hughes – you read excerpts from two about this approach in preparation for today’s discussion and reviewed a powerpoint presentation by Dr. Courtney Rennicke on DDP. We
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will later talk about your essays on how you might use DDP principles and practices in your clinical work. We will also discuss other attachment-focused interventions although in less detail.

Here are our learning objectives for our Module today:

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.

Intersubjectivity

A key theme in DDP is the importance of reciprocal interactions between mother and baby. That relationship is essential to our understanding of children who are insecurely attached.

Large Group Discussion: What do you see in these photos?
Note to Trainer:  Raise the following if not mentioned:

Clear reciprocity between each mother and infant:

- Eye contact
- Affect matching: the same intensity and rhythms of expression
- Gesture matching – heads toward one another
- Baby reaching out to mom who is gazing intently at baby

Lecture

This reciprocal interaction, as you know, is often called attunement. We talked briefly about attunement in our last Module. Today, we will go into greater detail. The term attunement refers to affect attunement – that is, the nonverbal communication that develops between the infant and parent. Infants engage in nonverbal communication with their parent and the parent engages in nonverbal communication with the infant. Both the parent and child use eye contact and facial expressions, voice tones, movement, gestures, and touch as a way of communicating with one another and showing interest and delight with one another. This creates emotionally rich times together.

Large Group Discussion: What do you see in these photos?
In Dyadic Developmental Psychotherapy (DDP), with which you are now familiar, the concept of attunement is broadened to a concept of “intersubjectivity.” Intersubjectivity holds three aspects of matching between parent and infant:

Affect

Attention

Intention or Cooperation

Let’s look at each of these.

Affect: Affect attunement is a process in which the parent and baby mutually create, match and share their affective states — that is, how they express their emotions, sentiments, and desires. Affect represents the nonverbal, bodily expression of one’s emotions, sentiments, and desires. The attuned parent matches the affective expression of her angry baby, without being angry herself. She matches the intensity and rhythm of his voice, his gestures and movements.
Large Group Discussion: What do you see in these photographs with respect to affect matching?

Note to Trainer: Comment that if the baby in picture #1 is agitated, then most likely the mother is animated, matching the baby’s voice and body movements. The baby in picture #2 is seeking warmth and closeness and the mother responds with warmth and closeness-seeking with the baby.

Attention: Joint awareness between the child and parent. The child is fully aware of the parent and the parent is fully aware of the child. Or the parent and child are aware of the same event or object. There is no intersubjectivity if the baby is looking at the mother or a toy and the mother is looking at the TV.

Large Group Discussion: What do you see in these photographs with respect to joint awareness?
**Intention or cooperation:** Complementary/reciprocal intention. The parent wants to know the child and the child wants to be known. The parent wants to enjoy being with the child and the child wants to enjoy being with the parent. The child wants to learn from the parent and the parent wants to teach the child. With joint intention, the parent and child are cooperating.

**Large Group Discussion:** What do you see in this photograph with respect to reciprocal intention?

When intersubjectivity is present, the child develops secure attachment. The child first is safe with his or her parents. The child can then explore the world through the safety of the parent as well as the parent’s experience with and knowledge about the world. The child develops greater autonomy and skills. Securely attached children have a good balance between reliance on their parents and self reliance.

**Large Group Discussion:** What do you see in these photos of children?
When intersubjectivity is absent, the child is not able to develop a sense of safety with his parents. The child does not have that foundation of safety from which to explore the world. Without that safety, the child does not have the platform to develop autonomy and self-reliance. The child also has difficulty learning about self, others, and the world because he has not shared in experiences with his parents. Lacking the experience of his parents’ experience of him, the child is unclear about his identity and he makes sense of the fact that his parents do not interact with him by assuming that he is bad or unlovable. Not having shared experiences of the world, the child often does not develop deep interest in the objects and events of the world.

When the parent and child do not match in affect, the child is at risk of developing emotional lability, since matched affect creates the co-regulation of his emotions which is crucial if the child is to be able to auto-regulate his emotions. And when there is an absence of complementary intention between the parent and child, which is the foundation of cooperation, the child is at risk of developing Oppositional Defiant Disorder.

**Large Group Discussion:** What do you see in these photos of children?
In the DDP model, there is express recognition that children who do not experience intersubjectivity with their parents develop behaviors that reflect the lack of the parent’s active presence in their lives.

**Exercise in Pairs: Still Face**

Let’s experience first-hand what it is like to be without intersubjectivity. This exercise is called the “Still Face” exercise. Please partner with another student.

To begin, one of you will be the story teller and the other the listener. The story teller will tell a story of something that has happened – it can be a very simple story of an event or experience. Tell something that you think is interesting or humorous. Do not tell something that is stressful for you. The other person listens, making eye contact, nonverbally responding. When I call out “Still Face,” the listener is to drop her head and not make any eye contact with the story teller. Story teller, I am asking you to continue telling your story if you can. Try to stretch yourself. If it proves simply too difficult to continue, please do not pressure yourself to do this. When I call out, “End Still Face,” the listener again raises her head, makes eye contact and nonverbally responds. I will call out “End of Exercise” and we will talk about how this exercise felt. Then we will switch the roles of story teller and listener.

*Notes to trainer:*

Allow about 75 seconds for the first segment; about 75 seconds for the “Still Face”; and about 75 seconds for the third segment.

After first round, debrief. Ask students, “How did it affect you?” Some common responses are:
• Anxious
• Disconnected from the story -- it lost its meaning
• Feeling disorganized
• Lost track of story
• Decreased motivation
• Anger at the listener for not listening
• Couldn’t continue telling the story

Ask students to change roles and repeat exercise.

Again, debrief.

Make the following points at the conclusion of the exercise:

• In this exercise, you were co-creating your story with your partner. You were telling the story and taking in the partner’s non-verbal responses and your partner was taking in your story and reacting to your story. Together, the story unfolded. Then, you “lost” your co-creator – your partner dropped away.
• As adults, notice the tremendous impact on you when intersubjectivity disappeared for just over minute.
• Imagine now what it is like for a baby. The baby is telling a story and needs the primary caregiver (usually the mother) to co-create the story. Imagine what it is like when the absence of intersubjectivity goes on for months. Also, you knew why the listener stopped listening. The baby does not and assumes that it is because she is bad or unlovable.

Large Group Discussion: How might a client feel when you function as a “still face” therapist, carefully controlling any response whatsoever as they are telling you their story. Do you think, based on this exercise, that clients might feel anxious, disconnected, disoriented?
10:00AM – 10:20AM  Introduction to DDP

As a brief summary, DDP:

- Is a treatment approach to trauma, loss, and/or other dysregulating experiences
- Is based on principles derived from attachment theory and research and also incorporates aspects of treatment principles that address trauma.
- Is a specialized form of Attachment-Focused Family Therapy which is utilized for all families

The key concepts of DDP are:

- DDP involves creating a safe setting in which the child can begin to explore, resolve, and integrate a wide range of memories, emotions, and current experiences, that are frightening, shameful, avoided or denied.
- Safety is created by insuring that this exploration occurs within an intersubjective context characterized by nonverbal attunement, reflective dialogue, acceptance, curiosity, and empathy.
- As the process unfolds, the client is creating a coherent life-story which is crucial for attachment security and is a strong protective factor against psychopathology.
- Therapeutic progress occurs within the joint activities of co-regulating affect and co-creating meaning. Dan Hughes calls this “Co-Co” therapy: co-regulation of affect and co-creation of meaning.

Look at Handout #6.1, Core Components of DDP – components that are also common in other evidence-based psychotherapies.
Small Group Discussion

Together, review the core components in Handout #6.1. Choose two of the components and discuss for each component: Why is this component particularly important when working with children and youth who have inexperienced insecure attachment, trauma and loss? How are you currently incorporating this component in your clinical practice? How might you deepen your practice in this area?

Allow about 5 minutes for this discussion.

Report Out

Allow about 5 minutes for small groups to report on their discussions.

Lecture

We are focusing on DDP today because it has a growing base of evidence that supports its efficacy. As you see in Handout #6.2, a number of studies have evaluated DDP and these have found improvements on CBCL measures (particularly on measures of the syndromes of withdrawn, anxious/depressed, social problems, thought problems, attention problems, rule-breaking behavior, aggressive behavior) for children undergoing DDP -- compared to children in the control group. In some studies, children in the control group showed no significant changes and in one study, children in the control group experienced significant worsening in some behaviors – anxiety/depression, attention problems, rule breaking behavior and aggressive behavior.

Handout #6.2 DDT Initial Experimental Studies
How does DDP create safety? It creates an “intersubjective context” – what we were just talking about and experiencing. How is an intersubjective context created?

Through:

- Empathy
- Acceptance
- Curiosity
- Nonverbal attunement
- Reflective dialogue

As you read, the foundation of intervention strategies in DDP is that the therapist and the parents/attachment figures have an attitude of PACE. Look at Handout #6.3: DDP and PACE and in your small groups fill in the chart on PACE.
Facilitate a discussion about what each component means and how the component would be used in the students’ clinical work.

Make the following points about each of the components if needed:

PACE stands for:

- **Playful**: Light, relaxed, exaggerated (affect/cognition), smile, do unexpected. Playfulness conveys a sense of hopefulness and generates a forward energy. Playfulness is not used as an effort to pull a person out of a negative emotional state.

- **Accepting**: Of thoughts, feelings, beliefs, wishes, memories, perceptions of behavioral events; nonjudgmental, unconditional regard (only behavior may be evaluated)

- **Curious**: Not-knowing, open, interested, act of discovery, surprise, “aha!”, never evaluated.

- **Empathetic**: Feeling-felt, joined, in the world of the other. Giving expression to affect vitality

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. Parents and attachment figures also use PACE. As Dr. Hughes says, “No lectures”.

Here are some key reasons that PACE is important:

- What we are asking of the child is emotionally stressful.
- PACE engages the child intersubjectively, while lectures do not.
- By maintaining an attitude characterized by PACE, we ensure that the child is not alone while entering that painful experience.
- The child has developed significant symptoms and defenses against that pain, most often because he was alone in facing it.
- When we help the child to carry and contain the pain within him, when we co-regulate the affect with him, we are providing him with the safety needed to explore, resolve, and integrate the experience.
- We do not facilitate safety when we support a child’s avoidance of the pain, but rather when we remain emotionally present when he is addressing and experiencing the pain.
10:50AM – 12:00PM  DDP: Initial Meetings with Parents

As the initial step in DDP, the therapist meets with the adoptive parents on their own. It is at this point that the assessment begins. Handout #6.4 provides a list of issues that are addressed through the assessment process. Let’s look at these issues together.

Handout #6.4 Assessment

- Some of the issues that need to be addressed relate to the child:
  - The child’s history: abuse, neglect, placements, attachments.
  - The child’s present symptoms: physical, affect, behavior, cognitive functioning

- The assessment also includes 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?

- The assessment also includes the therapist’s own observations of the child which we will talk about a bit later.

A primary goal of the first meeting with the parents is to establish safety with them. What does this mean? Dr. Hughes says that the therapist’s job is to like the parents through experiencing that:

(1) They are good people
(2) They are doing the best they can
(3) They care about their child or want to care about their child

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The therapist then communicates these experiences to the parents nonverbally and possibly verbally as well.

Can a therapist always like a parent?

Look at the following situation:

Beth and Tom come to see you because, as Beth informs you, their ten-year-old adopted son, Hank, lies constantly. Beth is furious that she cannot trust him to ever tell the truth. When you begin the interview, she talks constantly, reciting one example after another about what a liar Hank is. Tom sits passively by without saying a word. Beth is brimming over with anger and makes statements such as, “I can’t believe that we adopted this kid and now we have to live with a liar” and “I sometimes really hate this kid.”

Discuss together:

1. How could you find something to like about Beth and Tom?
2. What specific approaches might you use to develop a sense of “liking” them?

Following the report out, mention the following possible approaches if not discussed:

- If you can get Beth and Tom to say one thing that they like about Hank, you can like them for that.
- You can go back to their own history, asking questions like: Why did you adopt? What were your hopes and dreams when you adopted? Their responses may open the therapist up to many things about Beth and Tom that are likeable.
- You can ask them when they first doubted that they would be able to achieve their hopes and dreams. Such doubts may elicit sadness and even grief, not anger. As the parents become vulnerable, it is easier for the therapist to like them.
- You can respond to Beth and Tom as a real person, rather than as a neutral professional. The more real you are, the more that they can trust you and can see that you like them.
It is important to listen to Beth and Tom with no judgment. Be curious, accept what they say. It is their story and the therapist needs to create an environment in which they feel safe.

Lecture

Notice that in this example, Beth is engaging in venting – unproductive repetition of the same feeling. It is important that the therapist respond quickly to venting. Often, therapists become passive when a client begins to vent and takes control of the situation – this is not helpful to the child or to the adoptive parents. Let’s look at a way that a therapist can quickly intervene to stop venting.

Note to Trainer: Ask for a volunteer to join you and read the part of Beth. Two scripts (Demonstrated Role Play #1) are at the end of this teaching script.

Demonstrated Role Play #1: Beth

Beth: Look, Hank is nothing but a liar. I ask him if he has homework, he lies. I ask him if he took the bus home from school, he lies. I ask him if he ate the sandwich I made for his lunch at school, he lies. I ask him if he . . .

Therapist: Whoa, whoa, what you were saying about asking Hank questions about school . . .

Beth: Everything I ask him, he lies. He lies about what he does and doesn’t do; he lies about what he says and doesn’t say; he lies . . .

Therapist: Whoa, whoa, I need to really understand this . . .

Beth: But I am trying to tell you . . .

Therapist: I know but you were starting to mention several things bothering you and I really need to slow you down a bit in order to understand what is happening if I am going to help you. Let’s take a deep breath here and look together at what is upsetting
you with just one example and then we can begin to try to make sense of it, and even maybe start to try to work out what we might do about it.

[Discussion takes place]

Therapist: I can get now why you are so upset about Hank’s lies. They make it so hard to be able to help him. I know now that under your anger at him, you really want to be able to help him to have a better life. You haven’t given up. You keep trying—maybe in anger at times—but you don’t give up. He needs your commitment to him. You know, Beth, I was a bit hard on you. Are you okay?

Beth: Yeah, you were hard on me. But, you know, you were nice about. (Smiles)

Therapist: Laughs appreciatively.

Large Group Discussion: What skills did you see the therapist using to stop the venting?

Let’s now practice the “interruption of venting” skill.

Role Plays in Pairs

Please pair up with someone new. First, role play together scenario #1.

Note to Trainer: Queue the slide for Scenario #1. Allow a few minutes for the role play, call it to a close and ask participants to take a few moments to talk with one another about the experience. Then ask partners to switch roles and role play scenario #2. Queue the slide for Scenario #2. Allow a few minutes, call the exercise to a close, and ask participants to spend a few moments talking about the experience.

Scenario #1: Mary is a 36-year-old single adoptive mother. Her daughter, Bonnie, is an 8-year-old who experienced significant neglect as a baby and toddler and then entered foster care at age 3. In your initial session with Mary, she tells you that Bonnie just can’t relate to her. Bonnie won’t hug Mary or let Mary even get close to her before she begins whimpering. She has tried everything. Mary begins a long rambling tale of all
that she has tried, continuing to repeat “and that didn’t work”. As the therapist, what do you do?

**Scenario #2:** Henry and Tom are the adoptive parents of four-year-old Sammy who they adopted as an infant. The information about Sammy’s prenatal history is limited. Sammy has always been an active child but has become more so over the past year. Tom does most of the talking, explaining how Sammy almost “flies” around never sitting still. He begins to list all the ways that Sammy has damaged property in their home and in the yard. His list goes on and on. As the therapist, what do you do?

**Report Out**

- Were you able to stop the venting? How did you feel about stopping the venting?
- What worked and did not work?

**Lecture**

In the initial session with the parents, the therapist explores the parents' parenting stance and attachment history. It is important to begin this work in the first session. If you wait to begin to explore these issues later, adoptive parents will likely believe that you are blaming them for their child’s problems.

**Large Group Discussion:** To learn more about the parents’ parenting stance, what are the types of questions that we want to pursue with parents in the initial meetings with them?

*Add the following if not mentioned:*
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- Do they see anything positive about child?
- Do they understand why the child behaves this way?
- What type of discipline do they use? Are they willing to consider other forms of discipline?
- What is their level of empathy for the child?

Let’s look at **Handout #6.5 Parenting Profile for Developing Attachment.**

A therapist can use this tool, developed by Dr. Hughes, to help adoptive parents consider their perception of themselves as a parent and their perceptions of their spouse or partner as a parent.

**Small Group Work**

How would you introduce this tool to adoptive parents who have come to you because of their child’s emotional and behavioral challenges? Develop four or five talking points that you could use to support adoptive parents in completing this tool.

**Report Out**

*Ask small groups to share their talking points with the larger group.*

**Lecture: Talking with Parents about Their Attachment History**

It is important in the first session with parents to begin to talk with them about their attachment histories. This is important because their child’s intense behaviors may activate their own attachment
histories. Parents need to be securely attached to help their child be securely attached. Dan Siegel, in his book, *Parenting from the Inside Out*, suggests a number of questions that can be used to learn more about parents’ attachment histories. These questions include:

- Could you express anger as a child?
- Could you cry?
- Could you express your thoughts and feelings about your parents to them?
- How did your parents handle your anger? Your crying? Your expressing your feelings about them?
- What losses have you experienced in life?

Consider the case examples in Handout #6.6. How might these parents’ attachment histories impact them in their parenting of their adopted children now?

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 fended for themselves. She was not close to her parents and they seemed to be happy with everyone staying at arm’s length.
Ask for groups to report out on their discussions on Case #1 and Case #2.

Look at Handout #6.7, Questions for Parental Self Reflection which Dr. Hughes has borrowed from Dan Siegel’s book, *Parenting from the Inside Out*. This can be given to parents to go over after the first session and can be discussed in the second session. These are important questions in your assessment and the development of the treatment plan.

**Handout #6.7 Questions for Parental Self Reflection**

An adoptive parent may say: “Why are you asking me all of these questions? We didn’t come here about us. We came here about our child.”

**Large Group Discussion:** How would you respond to these comments?

**Lecture**

Here are some ways that Dr. Hughes suggests that a therapist might respond:

“I am sorry if you think that I am blaming you for your child’s problems. That’s not my reason at all for bringing up your own history. . .

“Your child’s behavior can activate issues that you bring from your own childhood.”
“You have to be the healthiest, strongest parent in the neighborhood to help this child. You cannot be a mediocre parent. For that reason, it is helpful to talk about how your child’s behavior can activate feelings in you in ways that you may not expect.”

“You did not cause the child’s problems but you are critical to the solution. If you have unresolved attachment issues, you cannot be part of the solution.”

Role Play in Pairs

Return to your original role play partner. Review together the questions for parents’ self-reflection from Dan Siegel’s book. Role play with one person being the therapist and one an adoptive parents. Select questions that you want to use in your work with the adoptive parent. After 5 minutes, I will call time and then switch roles.

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? How were they 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”? Do they 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 these people?

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?

What was the experience like for you as therapists? As adoptive parents? How helpful did you find the questions to be in your work together?

Let’s watch a video in which Dr. Hughes works with adoptive parents. In this video clip, we will see his work with Gail and Chuck.

VIDEO: Part 3 Parents: Gail and Chuck (20 minutes)

Notes to Trainer:

1. Play the video to the 6:00 minute mark. Stop the video and ask: What are your thoughts about how Dr. Hughes starts the session with Gail and Chuck – and especially Gail?
2. Play the video to the 12:15 minute mark. Stop the video and ask: What did you see Dr. Hughes doing to connect with Gail? With what results?
3. Play the video to the 19:45 minute mark. Stop the video and ask: How does Dr. Hughes response to Gail’s anger and descriptions of her pain? How do you see Gail’s own attachment history being brought into the session?

   End the video presentation at this point.

Lecture
You may wonder how the work will proceed following this session. Here are some thoughts from Dr. Hughes about the next session:

- Explore how Gail is doing after her hard work on her own vulnerability in the earlier session.
- Bring Chuck into the session fully and help him with his challenges.

In terms of the course of treatment, Dr. Hughes says:

- He would be confident that in another 2 to 3 sessions, it would be possible to bring the daughter into the sessions. Gail will experience her own vulnerability and express her vulnerability to the therapist and the therapist will express empathy for Gail’s vulnerability. The daughter will be able to see how vulnerable her mother is and relate to her mother’s vulnerability and to her own.

- If the therapy is not successful with Gail, Dr. Hughes would say to the parents, “Your child is challenging you because of your own history. You were not raised to parent a child with your child’s issues. I need to ask you to work with your own therapist on these issues. We will continue to remain in contact as you do this work.” Dr. Hughes states that he would either hold off on the child’s therapy if the parents’ therapy is short term (2 to 3 months) or if their therapy is longer, he might begin family therapy while the parents continue to work closely with their own therapist. It would be important for the parents’ therapist to understand adoption and to be open to communication with the DDP therapist. The parents’ therapist would most likely use a relationship-based model of therapy and have a firm understanding of attachment and adoption issues.

Let’s turn now situations in which parents are angry or upset with the child and how in DDP, we make decisions about including or not including parents in the work with the child or young person.

Return to your small groups and discuss how you would handle the situations presented in Handout #6.8.
What would be your approach if Yvonne screamed at Michael in Scenario #1? If Yvonne cried in Scenario #2?

After the discussion, cover the following:

- In some cases, the parent will simply be too angry with the child to be engaged in therapy with the child. Part of the assessment with parents is assessing the quality of the current home situation for the child. It is important not to assume that the adoptive family is automatically an appropriate family for the child. If the parent expresses uncontrolled anger or hate toward the child (such as by screaming about the child in front of the child), the therapist meets with the child alone. Safety requires that the parent not be in the room with the child.

- However, the parent does not have to be perfect. Parents can become angry in the session. They have to be willing and able to follow the lead of the therapist as to what they might say or do differently that would improve their relationship with their child, not hurt it. If they make a mistake in the session that jeopardizes their child's sense of safety, they will apologize and work to not make that mistake again.

Lecture

When you are confident that the parent can do the job, you will want the parent to be present in the therapy sessions. The child has an attachment figure: his or her adoptive parent(s). The child does not know how to have a relationship and is now living with a parent who provides a relationship. The therapist wants the parent there so that child can attach to the parent, not to therapist. If a therapist cannot do this, he or she needs to refer the family to another therapist. We will talk about this more later.

The adoptive parents’ active presence in therapy with the child:

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Module #6 Attachment

- Increases the child’s psychological safety
- Increases the child’s readiness to rely on significant attachment figures in his life
- Strengthens the child’s ability to resolve and integrate the dysregulating experiences that are being explored

The goal in therapy is to lead or guide the child toward the parent, not toward the therapist. A therapist can begin to think, “hey, this kid is really opening to me” and may be inclined to leave parents out. The child may be quite charming to the therapist and quite rude and hostile to the parent. The therapist may believe that he or she is the one the child can relate to – it is important to remember that this may be part of the child’s manipulation based on the child’s past trauma and attachment difficulties. Dr. Hughes says: “Don’t pretend that an hour of week will rescue the child.”

How does the therapist prepare parents for the sessions with their child? Dr. Hughes prepares parents in the following ways:

- He emphasizes that safety is crucial. Safety precedes everything. In therapy, the therapist is saying to the child that he or she is safe in the Module. The child can let down his or her guard.
- The therapist tells the parents what the session will look like. If the parents have any reservations about the structure of the sessions, this is addressed and resolved before the joint sessions begin.
- He tells parents that if he thinks that the parent is saying or doing something that will hurt their relationship with their child, he will wave a hand toward the parent which means that he will suggest something that they might say or do that would help their relationship with their child. Parents must agree to this approach or he does not conduct a joint session with the parent and child. If the parent does not stop talking when he waves a hand, he immediately addresses that with them before continuing.

DDP actively engages the parents from the outset of therapy. DDP goes into the attachment relationship and the child’s lack of trust. The therapist must address these issues and through addressing these issues, help resolve the trauma. Attachment and trauma are interwoven – which is an important reason for bringing parents into therapy – and the child’s trauma is birth parent-related. In DDP, the presence of an emotionally strong and available attachment figure helps to resolve the trauma, and the act of resolving the trauma, facilitates the attachment. In this approach, the therapist assesses the parents’ readiness and ability to provide emotional support to their child and also provides the parents with emotional support.

Here are the key roles of the adoptive parents in the therapeutic work with their child as described by Dr. Hughes:

1. Help the child to feel safe.
2. Communicate PACE, both nonverbally and verbally.

3. Help the child to regulate any negative affect such as fear, shame, anger, or sadness.

4. Validate the child’s worth in the face of trauma, loss, and shame-based behaviors.

5. Provide attachment security regardless of the issues being explored.

6. Help the child to make sense of his life so that it is organized and congruent.

7. Help the child to understand the parents’ perspective and intentions toward him.

12:00PM – 1:00PM Lunch

1:00PM – 2:00PM Assessment of the Child

The assessment of the child involves the gathering of information in different ways. We are going to look at:

- Review of prior assessments
- Gathering information from the child’s adoptive parents
- Assessments as samplers of therapy

Review of prior assessments

The therapist obtains and reviews prior assessments. Some assessments of children, however, are quite weak and/or unreliable. Assessments may go to one extreme or another: every child is assessed as having RAD or the assessment fails to address attachment issues at all and immediately gives the child a diagnosis of ODD.

Gathering information from adoptive parents

In the interviews with the adoptive parents, the therapist begins to gather information about the child.
Return to your small groups and outline the questions you would ask parents to begin to understand what is happening with the child?

Ask the groups to report out on the questions moving through the small group asking about 2 or 3 new questions. Review the following questions if needed:

1. What is the child’s history? Has the child experienced abuse, neglect, abandonment, lack of adequate care, and/or multiple placements?

2. What are child’s symptoms?

3. Is the child extremely controlling?

4. How does the child handle frustration? For example, does the child scream, run away, or refuse to turn to his/her parents?

5. Can the child accept comfort and support when disappointed or frustrated?

Assessments are samplers of a therapy session.

In the initial sessions with the child, the therapist engages with the child and notices the child’s eye contact and ability to relate to the therapist and adoptive parents. Through engagement with the child, the therapist begins to assess the child’s attachment security – an integrated sense of self with no big blockages or gaps.

Return to Handout #6.4 where, as you see, the therapist is assessing as she observes the child and participates in interactions with the child.
The therapist considers the child’s:

- Interactions with the therapist herself and with the parents
- Nonverbal communication
- Sense of humor
- Level of empathy
- Inner state: the child’s access to affective life
- Ability to regulate

The therapist also assesses the overall response to the session: affect, cognition, behavior, and interpersonal.

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

Cognition: reflecting behavior

Behavior: what the 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.

Let’s watch a video of Dr. Hughes working with a child, Jake. Please note that Dr. Hughes has worked with Jake over a period of time. You may find his approach different than your clinical style. Make note of how Dr. Hughes works and think also about how you might work with Jake.

VIDEO: Part 2: Children: Jake

Notes to Trainer:

1. Play the video to the 5:03 minute mark. Stop the video and ask: How do you see Dr. Hughes engaging and holding Jake’s attention as he begins this session with Jake and his parents?
2. Play the video to the 9:50 minute mark. Stop the video and ask: How did Dr. Hughes introduce Jake’s relationship with his siblings and begin the work of reducing Jake’s shame?
3. **Play the video to the 14:00 minute mark. Stop the video and ask:** How do you see Dr. Hughes using the principles of DDP with Jake?

*End the video presentation at this point.*

**Large Group Discussion:** Do you have other thoughts about this work with Jake and his parents?

**Lecture**

When asked about what would happen next in Jake’s therapy, Dr. Hughes states that the therapeutic process would continue. Jake would be helped to reply on his parents and on the therapist to create his story. A focus would be on Jake’s shame and fears of loss and abandonment that arise from his unsafe experiences with his birth parents. The therapist would continue to help him turn to his adoptive parents and be vulnerable with them. The therapist would continue to work with Jake in the context of his attachment history, helping him make sense of his story and accept that his adoptive parents are safe and love him.

**Lecture**

Many children and young people whom you see will have attachment difficulties. The assessment process allows the therapist to reach certain working hypotheses about the child’s experiences.

One framework for assessing the child is the concept of Developmental Trauma Disorder developed by Dr. Bessel van der Kolk. Handout #6.9 provides information about DTD.
Let’s look at what Dr. van der Kolk says:

“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.”

Large Group Discussion: What do see as the implications of this statement for effective therapy for these children?

Note to Trainer: Make the following points:

- This is why it is important for the therapist to take a directive as well as a non-directive stance in attachment-focused therapy. These children will not bring up their fears and traumas on their own.
- This is also why the affective-reflective dialogue is so important – these children will not be able to connect what they are currently doing and feeling to past trauma.

In assessing children and young people and reaching a diagnosis, there may be a tendency to rely on PTSD as the diagnosis. As you know, PTSD is defined as a serious condition that can develop after a person has experienced or witnessed a traumatic or terrifying event in which serious physical injury has occurred or was threatened. It is the lasting consequence of traumatic ordeals that can cause intense fear, helplessness or horror.

Dr. van der Kolk writes that: “The PTSD diagnosis does not capture the developmental effects of childhood trauma.”

Large Group Discussion: Why do you think that Dr. van der Kolk says this?

Note to Trainer: Review the following after the discussion:

Dr. van der Kolk gives a number of reasons for the inadequacy of a PTSD diagnosis including:

- The disturbed attachment patterns
- The rapid behavioral regressions and shifts in emotional states
- The aggressive behavior against self and others
• The failure to achieve developmental competencies
• The anticipatory behavior and trauma expectations;
• The apparent lack of awareness of danger and resulting self-endangering behaviors
• The self-hatred and self-blame
• The chronic feelings of ineffectiveness

Finally, Dr. van der Kolk writes: “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.”

Large Group Discussion: Does this sound just like DDP? How?

Notes to Trainer: Make the following points:

• Yes, it is exactly what we have learned about DDP. DDP puts safety first as the priority.
• DDP assists children deal with traumatic re-enactments through affective-reflective dialogue and the therapist speaking for the child.
• The goal of DDP is to co-regulate and co-create an integrated narrative for the child.

“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.”

Large Group Discussion: What are the implications of children’s tendency to repeat the trauma for our therapeutic work with traumatized children?

Notes to Trainer: Make the following points:

• It is to be expected that these children will see their adoptive parents in the same way that they experienced their birth parents and other caregivers prior to being adopted.
These patterns of relating are familiar to them. This tendency to repeat the trauma underscores the importance of actively engaging adoptive parents in the therapy in order to help the child differentiate the adoptive parents from the birth parents.

2:00PM – 3:30PM DDP Therapy with Children and Youth and Their Families

[Note to Trainer: Feel free to call a break at an appropriate time during this segment]

Now let’s focus on the clinical work in DDP with children or adolescents. It is not possible in this short time to cover all aspects of DDP and we will be spending some time watching a video of clinical work with Jenny and her adoptive mother. To briefly review some key points on the clinical work in DDP:

• **Safety precedes everything.** The therapist must create a safe environment for the child where she is able to let down her guard. At the same time, the therapist must balance safety with exploration. In DDP, we do therapy like playing with a toddler – matching affect, attention and intention as we talked about earlier. Most adults can do this with babies or with friends over lunch. Most therapists, however, were trained to be neutral and for that reason, we may need to strengthen our skills in getting an intersubjective relationship developing with our client. This is why practice is so essential.

• **The therapist has to care about the child** -- experience something about the child that the therapist likes. The therapist has to enjoy being with the child, discover what is good for the child and experience the child’s sadness. The child needs to know that he is special to the therapist.

• **A key feature of DDP is Affective/Reflective Dialogue.** 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.

• **Curiosity is a vital ingredient in DDP.** Let’s briefly look at a common situation in therapy: a child who is dealing with past trauma and does not want to talk. A therapist might engage a child who does not want to engage – with the therapist using the power of curiosity. Would someone volunteer to read the part of Mark, a 12 year old?
Demonstrated Role Play #2: Mark

Therapist: Hey, it is good to see you today.

Mark: If you say so.

Therapist: Yeah, it is good to see you today!

Mark: [Shrugs]

Therapist: So, how are things going?

Mark: Look, you don’t care about me. Why should I tell you anything?

Therapist: So, you think that I don’t care about you. It makes me feel really sad that that you don’t think that I care about you. If you think that, I can see why you don’t want to talk with me.

Mark: Here’s the deal. I don’t want to talk. Things will never change.

Therapist: So, you don’t want to talk. Hmmm . . . If you don’t think that therapy will help you at all—you said that you don’t think you’ll ever change. I can see why you don’t want to talk.

Mark: You don’t care about me. You are only doing this because you are getting paid!

Therapist: You are right. I am getting paid—and you think that is the only reason that I’m talking with you. Again, I can sure see why you don’t want to talk with me!

Note to trainer: Thank the student who played Mark.

Large Group Discussion: What are your thoughts on this exchange between the therapist and Mark?

Make the following points if needed:
1. The therapist accepts, is curious about, and has empathy for each statement that the child makes. The therapist wants to know more.
2. The therapist does not fight the resistance. Instead, the therapist goes with the resistance.

Look at Handout #6.10 -- prepared by Dr. Hughes -- that describes a variety of ways that a therapist might respond to a child who says “You don’t really care!”

Handout #6.10. Affective/Reflective Dialogue

Small Group Work

Review Handout #6.10 responses to a child saying “You don’t care.” Then choose two of the other child statement that you may hear and develop together at least three potential responses that you might have to a child who make each of the statements.

Report Out

Ask each group to share their responses with the larger group.

Lecture

- A key aspect of DDP is non-verbal communication. In DDP, the experiential precedes the reflective. It is important to build a foundation bodily. The non-verbal communication is the body communicating. When a child “gets” that the therapist “gets” his body expression, the child is able to experience the feelings and join in a reciprocal relationship with the therapist.
The reciprocity primes that child to more fully experience his emotions. The therapist needs to be sensitively aware of the nonverbal expressions of children and their parents, help to make these expressions verbal, and help to create congruence between the nonverbal and verbal.

In DDP, the therapist is aware of the child’s nonverbal meaning and matches the affect of the child with vitality. How does the therapist do this? Dr. Hughes lists the following about nonverbal communication:

- The therapist’s gaze is direct, warm, open, interested, responsive.
- The therapist’s voice is variable, responsive, relaxed, open, animated, thoughtful, alive, empathetic.
- The therapist’s gestures are animated, expansive, dramatic, responsive
- The therapist’s posture is open, moving/leaning forward

Let’s watch a video of Dr. Hughes working with Jennie, a child who does not want to talk, and her adoptive mother.

VIDEO: Children: Part 2: Jenny

Notes to Trainer:

1. Play the video to the 2:57 minute mark. Stop the video and ask: How does Dr. Hughes respond to Jenny’s lack of response?
2. Play the video to the 6:10 minute mark. Stop the video and ask: What might be Dr. Hughes’ goals in having a discussion with Jenny’s mom about Jenny in front of Jenny?
3. Play the video to the 12:35 minute mark. Stop the video and ask: As Dr. Hughes turns to Jenny, how does he use DDP principles in his work with her?

End the video presentation at this point.
Large Group Discussion: Do you have any other thoughts about Dr. Hughes’ work with Jenny and her mom?

Small Group Work

Handout #6.11

Return to your small group. Think of a case in which a child with whom one of you has worked where the child engaged in one or more of the child behaviors listed in Handout #6.11. Discuss what you believe was under the child’s behavior. Think about a case in which a parent engaged in one or more of parent behaviors listed in the Handout and what you believe was under the parent’s behavior.

Report Out

Ask for an example of one case involving a child and one case involving a parent. Facilitate a discussion of these cases.

Lecture: Past Trauma

DDP also looks at past trauma on its own. An adoptive parent may be ambivalent about bringing up the pain from the past, believing that discussing this pain will only bring more pain to the child.

Large Group Discussion: How might you respond to a parent who is expressing deep ambivalence about talking with the child about past trauma?
Lecture

Let’s look at the guidance that Dr. Hughes provides:

- Begin with deep empathy. Dr. Hughes recommends responding to the parent by saying something along these lines:
  - “I would be reluctant too if I did not think that it would help him in any way. But I know that if we do not bring it up, in the next 20 or 30 years, if anything in the world reminds him of his pain, it will come up – and it will be even worse for him. The pain is in his brain. You are doing so many things to keep him safe but he will never be safe from part of his brain which he has put a lock around. He could run into a person or experience a smell or be asked a question – and all of a sudden, the lock opens and terrorizes him. The only way for him to be safe is to help him unlock that part of his brain now with our love and comfort here for him. We can deal now with all that is locked in his brain. It is a birthright to know that history. Kids that know about their history will be in a much better place. We help them to go through it. We are here to comfort them. When a child can cry, and make sense of the trauma and as they do, you put your arms around them and comfort them, the child will feel so empowered and will be able to heal.”

- Anticipate that the adoptive parent may believe that the child is not developmentally ready to handle dealing with the trauma. As an example, a child, age 9, suffered sexual abuse at age 4. An adoptive parent feels that the child is not developmentally ready to discuss this trauma. The therapist says, “Your child now at age 9 is better able to deal with this trauma with parents who will comfort and hold her. Better now than at age 14 when she has sexual feelings and her body makes her aware of sexual feelings and thoughts.”

- A therapist may also say that it is not necessary to explore and make sense of past traumas, but this may be the therapist’s own issues. The therapist must be willing and able to go into the child’s trauma. The child’s attachment needs are most active as the child is thinking about the trauma, and the therapist cannot abandon the child. This is very demanding work and not everyone will be interested in or able to do this work?
Lecture: Homework?

A final issue about which there are often questions is whether in DDP the therapist gives “homework.” Dr. Hughes states that most commonly, one parent accompanies the child to therapy and the given “homework” is for the parent and child to tell the other parent what happened in therapy. This process will give the child a summary of what exactly happened in therapy and the chance to see his parents jointly communicating about him. Another example of homework that a therapist may give is when a child focuses exclusively on what makes him unhappy and goes wrong. The therapist says to the child, “You really remember all the hard times but what about the good times? Would you every day write down one of the hard times that happened during the day and one of the good times that happened during the day? Bring it to our next session and we can look at it together.”

Large Group Discussion

But, you did have homework! You were asked to write a couple of paragraphs based on your understanding of DDP after reading the initial materials. You described how you might incorporate DDP principles and practices in your clinical practice. Look back at your essay. Have your thoughts developed further now that you know more about DDP?

Note to Trainer: Allow at least 15-20 minutes for this discussion.

3:30PM – 4:15PM Other Attachment-Focused Interventions

Lecture

Let’s now look at other attachment focused interventions with which you may already be familiar or that may be new to you. Handout #6.12 provides short descriptions of evidence-based attachment-focused interventions.
First, let’s look at *Attachment and Biobehavioral Catch-up (ABC)*.

The Attachment and Biobehavioral Catch-up Intervention is a training program for caregivers of young children who have been neglected and caregivers of young children in foster care. It addresses the behaviors of children who have experienced early adversity. These children:

- Tend to push caregivers away when they are hurt or frustrated, acting as if they can handle things on their own.
- Especially need nurturing care; without such care, they are at risk for developing disorganized attachments to caregivers.
- Are often dysregulated at behavioral and biobehavioral levels.

The Attachment and Biobehavioral Catch-up (ABC) Intervention targets these three issues through 10 sessions. The intervention is tailored so as to be appropriate for working with foster parents and young children, and for working with neglecting birth parents.

The ABC Intervention is designed to help 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.
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The effectiveness of the Attachment and Biobehavioral Catch-up Intervention has been assessed through randomized clinical trials funded by the National Institute of Mental Health.

In these clinical trials, children were assigned to one of two interventions. In both groups, foster parents and birth parents received training in their homes for 10 Modules. The ABC intervention targeted children’s attachment and regulatory issues. In the alternate (treatment control) intervention, parents were helped to enhance children’s language development.

Children’s attachment and cortisol production were primary outcome measures. In both the foster parent study and the birth parent study, children whose parents received the ABC intervention showed better outcomes with regard to attachment and cortisol production.

1. Children in the ABC intervention developed secure attachments more frequently than children in the alternate intervention.
2. Children in the ABC intervention showed more normative patterns of cortisol production than children in the alternate intervention.

Discuss the cases on this Handout, addressing the questions before the two cases.

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.

Facilitate a discussion about the use of ABC in the two cases. Ask about students’ experiences with ABC if any.

Next, let’s look at PCIT: Parent-Child Interaction Therapy. Here is a brief video introduction to PCIT.

Video: What is Parent Child Interaction Therapy?

http://www.youtube.com/watch?v=1X2b-mmj2tk

[Note to Trainer: Click on “skip ad” to go to video; 1:38 minutes]
Lecture

To add to the video introduction:

- PCIT is a short-term, evidence-based intervention designed for families with children between the ages of 2 and 6 who are experiencing a range of behavioral, emotional, and family problems.
- This is a manualized parent training program that has two discrete phases:
  - Child-Directed Interaction (CDI) – which concentrates on strengthening parent-child attachment as a foundation for the next phase
  - Parent-Directed Interaction (PDI) – which emphasizes a structured and consistent approach to discipline
- Throughout treatment, emphasis is placed on the interaction between the parents and the child due to specific theoretical assumptions about the development and maintenance of externalizing behavior in children.
- The protocol is assessment driven and is not time limited. Progress in the parent-child interactions is coded at each session and treatment is completed when parents have mastered the skills of CDI and PDI and the child’s behavior is within normal limits.

The next video is an interesting role play of PCIT using stand-in play animals to represent the therapist, parent, child and the child’s current caregiver. Have fun with this and learn about PCIT!

Video: PCIT by Lindsay and Lissette

http://www.youtube.com/watch?v=cl-cQSEmarg [7 minutes]

Large Group Discussion: What are your experiences and thoughts about PCIT?

Finally, let’s consider Attachment-Based Family Therapy (ABFT).
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. It is manualized and empirically-based. 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 sessions 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 sessions 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.

Look at Handout #6.14 and read a case example of ABFT – a case involving Karla and her adoptive mothers, Julie and Sally. After reading the case, discuss the process that ABFT uses and how you might incorporate any of these practices into your own clinical work.

**Handout #6.14 Karla**

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 session, 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 wholeheartedly agreed to this goal, but Karla remained skeptical. The therapist respected this resistance and just invited Karla 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 session. 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.

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In the fourth session, the therapists brought Karla and her mom 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.

Facilitate a short reporting out of the small group discussions.

4:15PM – 4:30PM Summary and Closing

We have come to the close of our Module today on attachment and DDP. Please ask yourselves the following questions. Can I;
Module #6 Attachment

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 DDP 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?

As a result of this session, you should be able to answer “yes” to each of these questions. If not, please feel free to talk with me after the class and please review the Module materials.

In your email inbox, you will find a message with a link to a brief online survey for you to provided feedback on today’s workshop. It will ask you to rate the quality and relevance of the workshop content and the effectiveness of the learning activities, to identify the strengths of the training Module, and to recommend ways that the training can be improved. Please follow the link in the email and provide the feedback right ways while the Module experience is fresh in your memory.

The next Module will focus on adopted adolescents’ identity development. Please go to the website for your pre-Module assignments.

Thank you for your attention. See you ________ (next week/ month)!
Demonstrated Role Play #1: Beth

Beth: Look, Hank is nothing but a liar. I ask him if he has homework, he lies. I ask him if he took the bus home from school, he lies. I ask him if he ate the sandwich I made for his lunch at school, he lies. I ask him if he . . .

Therapist: Whoa, whoa, what you were saying about asking Hank questions about school . . .

Beth: Everything I ask him, he lies. He lies about what he does and doesn’t do; he lies about what he says and doesn’t say; he lies . . .

Therapist: Whoa, whoa, I need to really understand this . . .

Beth: But I am trying to tell you . . .

Therapist: I know but you were starting to mention several things bothering you and I really need to slow you down a bit in order to understand what is happening if I am going to help you. Let’s take a deep breath here and look together at what is upsetting you just one example and then we can begin to try to make sense of it, and even maybe start to try to work out what we might do about it.

[Discussion takes place]

Therapist: I can get now why you are so upset about Hank’s lies. They make it so hard to be able to help him. I know now that under your anger at him, you really want to be able to help him to have a better life. You haven’t given up. You keep trying—maybe in anger at times—but you don’t give up. He needs your commitment to him. You know, Beth, I was a bit hard on you. Are you okay?

Beth: Yeah, you were hard on me. But, you know, you were nice about. (Smiles)

Therapist: Laughs appreciatively.
Demonstrated Role Play #1: Beth

Copy #2

Beth: Look, Hank is nothing but a liar. I ask him if he has homework, he lies. I ask him if he took the bus home from school, he lies. I ask him if he ate the sandwich I made for his lunch at school, he lies. I ask him if he . . .

Therapist: Whoa, whoa, what you were saying about asking Hank questions about school . . .

Beth: Everything I ask him, he lies. He lies about what he does and doesn’t do; he lies about what he says and doesn’t say; he lies . . .

Therapist: Whoa, whoa, I need to really understand this . . .

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Therapist: I know but you were starting to mention several things bothering you and I really need to slow you down a bit in order to understand what is happening if I am going to help you. Let’s take a deep breath here and look together at what is upsetting you just one example and then we can begin to try to make sense of it, and even maybe start to try to work out what we might do about it.

[Discussion takes place]

Therapist: I can get now why you are so upset about Hank’s lies. They make it so hard to be able to help him. I know now that under your anger at him, you really want to be able to help him to have a better life. You haven’t given up. You keep trying—maybe in anger at times—but you don’t give up. He needs your commitment to him. You know, Beth, I was a bit hard on you. Are you okay?

Beth: Yeah, you were hard on me. But, you know, you were nice about. (Smiles)

Therapist: Laughs appreciatively.
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Therapist: Whoa, whoa, what you were saying about asking Hank questions about school . . .

Beth: Everything I ask him, he lies. He lies about what he does and doesn’t do; he lies about what he says and doesn’t say; he lies . . .

Therapist: Whoa, whoa, I need to really understand this . . .

Beth: But I am trying to tell you . . .

Therapist: I know but you were going on for several minutes and I really need to understand what is happening if I am going to help you. Let’s take a deep breath here and look together at what is upsetting you.

[Discussion takes place]

Therapist: Thank you so much for caring so much about Hank. Hank is really lucky to have such caring and loving parents. You know, Beth, I was a bit hard on you. Are you okay?

Beth: Yeah, you were. But, you know, you were nice about. (Smiles)

Therapist: Laughs appreciatively.
Demonstrated Role Play #2: Mark

Copy #1

Therapist: Hey, it is good to see you today.

Mark: If you say so.

Therapist: Yeah, it is good to see you today!

Mark: [ Shrugs ]

Therapist: So, how are things going?

Mark: Look, you don’t care about me. Why should I tell you anything?

Therapist: So, you think that I don’t care about you. It makes me feel really sad that that you don’t think that I care about you. If you think that, I can see why you don’t want to talk with me.

Mark: Here’s the deal. I don’t want to talk. Things will never change.

Therapist: So, you don’t want to talk. Hmmm . . . If you don’t think that therapy will help you at all—you said that you don’t think you’ll ever change. I can see why you don’t want to talk.

Mark: You don’t care about me. You are only doing this because you are getting paid!

Therapist: You are right. I am getting paid—and you think that is the only reason that I’m talking with you. Again, I can sure see why you don’t want to talk with me!
Demonstrated Role Play #2: Mark

Copy #2

Therapist: Hey, it is good to see you today.

Mark: If you say so.

Therapist: Yeah, it is good to see you today!

Mark: [Shrugs]

Therapist: So, how are things going?

Mark: Look, you don’t care about me. Why should I tell you anything?

Therapist: So, you think that I don’t care about you. It makes me feel really sad that that you don’t think that I care about you. If you think that, I can see why you don’t want to talk with me.

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Therapist: You are right. I am getting paid—and you think that is the only reason that I’m talking with you. Again, I can sure see why you don’t want to talk with me! —
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 24Ss 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.
**Handout #6.3  DDP and PACE**

<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>
<td></td>
</tr>
<tr>
<td>Curious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathetic</td>
<td></td>
<td></td>
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</tbody>
</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.

(behavior - 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 session: 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</th>
<th>My Perception of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of Self</td>
<td>Spouse/Friend</td>
</tr>
<tr>
<td>(1=very little 5=very much)</td>
<td></td>
</tr>
</tbody>
</table>

1. Able to maintain a sense of humor
2. Comfortable with giving physical affection
3. Comfortable receiving physical affection
4. Ready to comfort child in distress
5. Able to be playful with child
6. Ready to listen to child’s thoughts and feelings
7. Able to be calm and relaxed much of the time
8. Patient with child’s mistakes
9. Patient with child’s misbehaviors
10. Patient with child’s anger and defiance
11. Patient with child’s primary two symptoms
12. Comfortable expressing love for child
13. Able to show empathy for child’s distress
14. Able to show empathy for child’s anger
15. Able to set limits, with empathy, not anger
16. Able to give consequence, regardless of his response
17. Able and willing to give child much supervision
18. Able and willing to give child much “mom-time”
19. Able to express anger in a quick, to the point, manner
20. Able to “get over it” quickly after conflict with child
21. Able to allow child to accept consequence of choice

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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 fended 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.
Module #6 Attachment

- 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 sessions 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 sessions 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.
Handout #6.14 Attachment-Based Family Therapy: Karla

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 session, 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 sessions. 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 session, 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.