**Dyadic Developmental Practice, Psychotherapy and Parenting**

**(DDP)**

**Level One**

Introducing a Framework for Therapy and Parenting Developmentally Traumatized Children

DDP Level One Training Book

**Venue**: Australian Childhood Foundation

**Organization**: Australian Childhood Foundation

**Dates:**

**Trainer:** Sian Phillips

**Attendance Record**

Level One and Two are both stand-alone trainings. They are also part of the requirements for individuals who apply for DDP certification. Your trainer therefore needs to collect information to confirm your attendance at the training. This is also helpful to us if you lose a certificate and request a replacement. You will be asked to supply your name, email address (indicating home or work), profession, and your work organisation. This information will be stored on our online database.

**Staying in Touch**

Google group forum: This forum is USA based and is called ‘DDP Institute’. For an invite to join please email: [ddpi.admin@ddpnetwork.org](mailto:ddpi.admin@ddpnetwork.org).

DDP Network Newsletter: You can subscribe to the newsletter via the website <http://ddpnetwork.org/ukemail> This will enable you to receive emails about relevant DDP-related events or information. You can also scan this QR code to subscribe.



(Your trainer will also give you an opportunity to give consent to be added as a DDP Newsletter subscriber during the training, if you prefer.)

**Continuing Your DDP Development**

Once you have completed the DDPI approved DDP Level One training (28 Hours) you may want to consider how you can continue to develop your DDP skills.

1. Attend a DDP Level Two training (28 hours) with a DDPI approved Trainer
2. You can engage in a period of supervised practice with a certified and experienced DDP practitioner or a certified DDP consultant. This supervision can standalone or, if you are suitably qualified, can help you work towards the practicum.
3. You can attend local study days, special interest groups and national conferences. Details of these can be found on the website and via the newsletter.
4. If you have an appropriate degree in mental health, social care or education and/or a degree in a relevant therapy and you are registered with a relevant professional body you can commence the DDP practicum to become a certified practitioner. This is a supervised skills-based process that requires a minimum of 10 recorded reviews of your DDP work. Individuals who work with parents or caregivers only or who work in educational settings can request to be certified. The practicum has the same steps regardless of the type of work you are submitting for review.
5. Your organisation can work towards certification. The Organisational Certification Practicum is designed to lead an organisation to transform its culture and philosophy of care to embody the principles, values and skills of the DDP approach. The Practicum is the core of the Certification process that includes implementation of the Action Plan; ongoing consultation, supervision and training with the Primary Consultant; and creation of the Portfolio of Evidence. It is an active process of staff training, program/service evaluation and development, and organisational change that results in meeting the Certification Requirements.

Note: Applicants for the practicum and current members of DDPI need to carry their own professional indemnity insurance. The policy must maintain limits at least equal to those required by the practitioner’s professional body. In exceptional circumstances applicants can apply to be covered with such insurance by the organisation by whom they are employed.

Training Institute - Dyadic Developmental Psychotherapy Institute (DDPI®)

UK Community Interest Company - DDP Connects UK (CIC)

Information about both these organisations, events and certification is included in the DDP Network website: [**www.ddpnetwork.org**](http://www.ddpnetwork.org)

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**DDP LEVEL ONE: PROGRAM**

This four-day Level One training introduces Dyadic Developmental Practice, Psychotherapy and Parenting (DDP). Participants are asked to read the Attachment-Focused Family Therapy Workbook by Daniel A. Hughes, which underpins this training. Level One represents 28 hours of DDP training. This will provide the knowledge and practice necessary for attendees to introduce DDP principles to their work with developmentally traumatised children and their families. Level One is a stand-alone training. It is also the first step toward certification as a Practitioner in DDP. While Level One is a necessary starting point, it does not enable participants to advertise or say that they are Practitioners in DDP or that they provide DDP-informed practice. This is stated on your certificate of attendance:

“This training equips the participant to understand the DDP principles and to introduce their use within his or her practice. Individuals need to attend Level One, Level Two and complete the DDP certification process before they are certified Practitioners in DDP.”

In Level One the core components of DDP will be presented and explored through discussion and practice exercises. This includes practicing communication using PACE (Playfulness, Acceptance, Curiosity and Empathy). Participants will explore the use of DDP as therapeutic work with families and as a parenting framework.

**Objectives**

* Understand the DDP framework
* Understand the theoretical foundations to DDP
* Learn about and practice using the core components of DDP
* Apply this framework to:

A therapeutic approach for children and parents

A parenting approach that can complement the therapeutic approach

Working with teams, networks, services and organisations

**Suitable for**

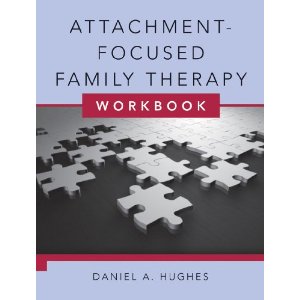
* Therapists working with developmentally traumatised children and their families or substitute families e.g. Clinical Psychologists, Child and Adolescent Mental Health Services (CAMHS), Independent Practitioners
* Professionals supporting children and young people who have experienced developmental trauma and their familiese.g. Social workers in fostering, adoption, children in care, children in need services and residential care settings, CAMHS, Education services, Paediatric services

This training is not designed to directly support parents and foster carers with the care of their own children and should not be seen as an alternative to local therapeutic intervention. However, in some circumstances, foster carers and adoptive parents can attend with the understanding that the training is primarily directed at practitioners. It is recommended that they attend alongside a support worker from their local service. Trainers will consider these requests on an individual basis.

**Next steps**  
A 6-month gap is recommended between attending Level One and Level Two in order to have time to develop the skills that are taught. Exceptions can be made, for example for experienced individuals who travel to another country to receive the training or if trainers infrequently travel to another country. Attending Level Two does not enable you to advertise that you or your organization provides Dyadic Developmental Psychotherapy. After Level Two you can apply to become certified as a practitioner in DDP, providing you have a relevant degree and are a member of a relevant professional organization. If you complete both Level One and Level Two and receive regular supervision or consultation from a Consultant or experienced Practitioner in DDP you can say you offer DDP-informed practice. It is also possible for an organisation to become formally recognised as practicing using DDP principles via the process of Organisational Certification. There is detailed information about the training and all certification processes in the DDP Network website <http://www.ddpnetwork.org>

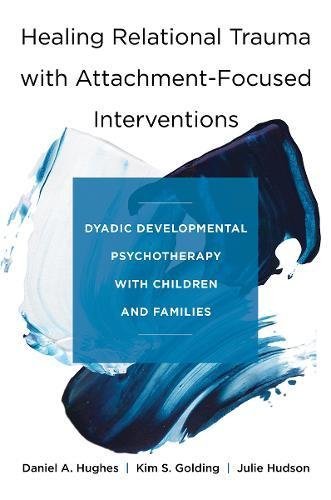
**Recommended Texts**

There are two textbooks which are recommended for those attending DDP training.

[](http://www.amazon.co.uk/gp/product/images/0393706494/ref=dp_image_z_0?ie=UTF8&n=266239&s=books)

Hughes, D. A. (2011) Attachment-Focused Family Therapy Workbook by Daniel A. Hughes, NY: W.W. Norton & Co.

And



Hughes, D. A.; Golding, K.S. & Hudson, J. (2019) Healing relational trauma with attachment-focused interventions: Dyadic Developmental Psychotherapy

**DDPI Diversity Statement**

Inherent in the values of DDP, embedded in the P.A.C.E. (Playfulness, Acceptance,Curiosity and Empathy) stance is our core belief that all people must be treated with dignity, compassion and respect.

Where differences of opinion, belief or culture exist, we choose to adopt an attitude of curiosity, acceptance and empathy to better understand those differences and perspective before we collaboratively move forward. We promote that all those we work with be treated without discrimination regardless of race, age, religion, sex, national origin, socioeconomic status, sexual orientation, gender identity or expression, disability, veteran status or source of payment.

Further, we at DDPI pledge to stay actively committed to making our community, training experiences, consultation services, parenting groups and therapy a more diverse culture that reflects the remarkable heterogeneity of the children, families, carers, educators and therapists we work with. We commit ourselves to actively integrate the ethos of diversity in our work and will continue to explore this issue and include a vigorous action plan for the future.



**YOUR TRAINER**

A person sitting next to a book shelf

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Sian Phillips, Ph.D.,C.Psych. *is a psychologist in private practice in Kingston. She received her Ph.D. from University of Toronto in 1996 and has been working with children and families in Kingston since that time. She specializes in the assessment of trauma and attachment difficulties and works with children, foster parents and adoptive parents using Dyadic Developmental Psychotherapy ®©.*

*Sian is a certified DDP therapist, consultant and international trainer. She is also an adjunct professor at Queens, supervising students in their clinical placements. Currently she is trying to help the education system better understand children who have experienced developmental trauma and has developed a specialized school program to work with children who cannot manage the regular school system due to their trauma and attachment difficulties. She is also consulting with local school boards to develop trauma informed schools and completing research examining the efficacy of a DDP approach in schools. This work can be accessed at* [*https://www.traumainformededucation.ca*](https://www.traumainformededucation.ca)

*Sian has two recent publications*

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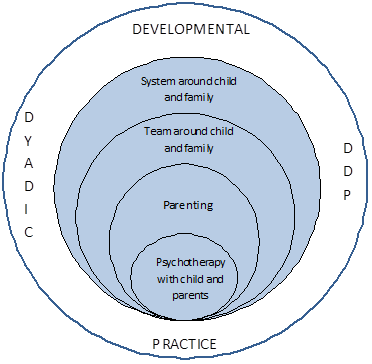
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*She also has two chapters in Art Becker Weidman’s book The Dyadic Developmental Psychotherapy Case Book (2011)*

Contact at:[**drsianphillips@psychologykingston.net**](mailto:drsianphillips@psychologykingston.net)

**INTRODUCTION TO DYADIC DEVELOPMENTAL PRACTICE**

* Therapist helps family members to develop healthy patterns of relating and communicating so all feel safe and connected. Children can then be helped to integrate the impact of experiences of trauma and loss, increase abilities to regulate emotional states, improve reflective functioning and socialise with adults and peers.



* These are achieved by helping parents with **day-to-day parenting** based on principles of PACE, as well as through **therapeutic sessions**. In addition, DDP can inform working with networks and teams involved with the family eg through consultation, training and supervision.
* Safety and connection leads to a reduction in the level of fear, shame or coercion that family members experience. Family members learn to be open to each other’s inner life, as well as the outward behaviour. This builds safety and develops reciprocal relationships. All members of the family learn to cooperate and  
   shared meaning is given to the family experiences.
* Emphasis on safety and healthy interactions is essential for developmentally traumatized children, lacking capacity for emotional regulation or reflective function. As these capacities are enhanced through day-to-day PACE-led parenting, and within therapy sessions, the child is enabled to respond to current experience and memories of past experience flexibly instead of through habitual rigid and repetitive responses.
* This provides a foundation to help the child, supported by her parents, explore unhappy and painful experience in the present but also in the past.
* The involvement of the parent in this therapeutic work is a critical part of its success. Parents support their children through their distress, fears and rage. By having the parents directly involved in therapy, the child receives experiences of increased safety and this enables increased attachment security with those who matter most.
* **The Importance of Relationships**: Reciprocal interactions are central to DDP. This approach recognizes that some children may not have learnt how to have reciprocal intersubjective relationships. Others may fear trusting an adult again.

**WHAT’S DIFFERENT ABOUT DDP AS A THERAPEUTIC APPROACH?**

**Emphasis on Safety**

Creating and maintaining safety for children and adults by keeping relationships central.

**Understanding Adult’s Attachment History**

Making connections, if needed for the adult, about the difficulty they are having with regards to their own attachment history and vulnerabilities

**Role of parent**

Working closely with one or both parents who are with the child in room. This includes preparation work and parental consultation alongside, and sometimes after, therapy.

**Contact with parent face-to-face or by telephone before and sometimes after sessions**

To find out how the time in between sessions has gone, how parent is feeling and prepare for the session about to happen, such as agreeing themes, events and interactions to focus on. This helps parents feel understood and emotionally regulated and enables responding with PACE to the child in the session.

**Therapist actively takes the lead including bringing in relevant themes**

Child or adult may have previously avoided these. The therapist actively explores ways to make connections and communicate with the child who may have given up on connecting, or never learned how to connect. Exploring the meanings of the behaviours that have weakened the connections is central in restoring these connections. This is where ensuring safety is crucial so child (and adult) remain open and engaged.

**Intersubjectivity**

One goal of DDP is to enable the child (or parent in parental consultations) to become engaged in intersubjective communication. The child seeing and experiencing how what he says and does has a positive impact on the therapist helps this. The therapist strives to communicate her experience of the strengths and vulnerabilities of who the child is, under his problem behaviours. One way to do this is through therapist making verbal and non-verbal initiatives and responses that are contingent on what has just happened in the room. This includes direct feedback from the therapist, connected to the affirming or empathic impact on her of behaviour, non-verbal or emotional responses from the child, or the parents’ responses.

**Focus on reciprocal relationships and emotional connections**

Reciprocal interactions between people in the room are the context where intersubjective communications occur.

A reciprocal interaction can be defensive - as opposed to open and engaged - thereby not providing much opportunity for intersubjective communication. Using connection to move from defensive to open and engaged is central.

**Timing and context for focusing on problem solving, tasks, ideas for behavioural management and parenting ideas**

Ensure emotion connections have been made and experienced by child prior to focusing on problem solving, parenting strategies or considering ideas that might help with child’s behaviour or feelings. This is often different from the expectations of the parent after a referral for help; hence the importance of working with parents to explain the approach before including the child in sessions.

**Overview of DDP**

**Parent focused - Create a safe setting and a consistent, reliable relationship with parents within which they can:**

* Receive non-judgmental and accepting responses to their current understanding of their child, the emotional impact the child is having upon them, and their parenting so far.
* Increase parental sensitivity, such as through communicating using PACE.
* Learn how to increase reciprocal interactions and intersubjective communication with their child.
* Be helped to make sense of their child's behaviour and emotional responses.
* Make emotional connections with their child before setting behavioral limits.

*In therapy, once the parent feels safe with the therapist, the practitioner and parent meet with the child to help the child to be safe. If the parent does not feel safe (non-defensive) in the therapy session, the child will not be safe.*

**Child focused - Create a safe setting within which children are helped by the practitioner, and/or their parents to**:

* Increasereciprocal interactionsand intersubjective communication.
* Co-regulate their affect and increase emotional regulation skills.
* Explore, resolve and integrate their memories, emotions and unhelpful behaviours associated with past and current experiences.
* Co-create their narrative (i.e. with another person actively involved in the process, develop a coherent life story or autobiographical narrative).

**DEVELOPMENTAL TRAUMA**

Complex trauma occurs when an individual has been exposed to multiple traumatic events with an impact on immediate and long-term outcomes. When complex trauma occurs through childhood; with early onset within the family; is chronic and prolonged; and impacts on development it is called developmental trauma. Developmental traumas, caused by a child’s attachment figures, either through their own actions or through failing to protect them from the actions of others, have more comprehensive and severe consequences.

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

“*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*[[1]](#footnote-1)

**Developmentally traumatized** children learn to survive without safety, security or connection.

* The children take control, and fear other ways of being.
* They do not want to connect as they fear that this will only confirm what they think they already know. They are not loveable and they will never be loved.
* They avoid intersubjective experience.

**Summary of the impact of developmental trauma**

(includes physical abuse, sexual abuse, emotional harm and neglect)

1. Fear**.** Sensitized to danger leading to distrust of others.
2. Hyper-vigilance: External - scan for danger, anticipate abandonment or attack. Internal - I am bad, wrong. No spare energy for anything else. See danger where it doesn't exist. React to imagined dangers in ways that bring about situations that are feared.
3. Identity develops around shame. Distorts experience of self and others. Feel flawed as a human being. Experience of badness can be kept out of consciousness because too painful to live with. Create barriers to relationships so others can't see what we see in self. Increases feelings of shame, isolation and loneliness.
4. Security of attachment is compromised.
5. Safety is destroyed and developmental attachment patterns become disorganised.
6. Intersubjective explorations are reduced and avoided. They don’t have the experiences that enable them to develop core beliefs or an internal working model that they are delightful, lovable and have a positive impact on the people around them.
7. Traumatic events are not explored and experienced in an integrative, coherent, intersubjective manner. They are not assimilated into the autobiographical narrative.
8. Traumatic events can create dissociation, as can subsequent memories or triggers of such events, thus causing rigid avoidance or “re-traumatisation”.

**BLOCKED TRUST** (Adapted from Baylin & Hughes, 2016)

**Brain-based development of Blocked Trust:**

**Caregiving Environment**  
Non-nurturing; distress met with pain, fear and/or silence

Inner life: terror and shame

**Stress Response System**  
High Alert

**Social Switching System**  
Biased for danger

Bottom-up reliance on self via heightened   
**Self Defense System.**  
Tiger/Opossum/  
Chameleon

Chronic hypervigilance.

Curiosity and new learning suppressed.

Suppress **Social Engagement System**

Can’t experience comfort or joy in relationship

Inhibit **Social Pain system**

Lack of top down social buffering to provide regulatory support.

Blocked trust describes the process of suppressing the need for comfort and companionship to survive neglect and abuse.

* The children learn not to trust that comfort and companionship will be safely given to them by their caregiver, because their initial cues to elicit these were met with pain, fear or silence.
* The children learn to suppress feeling the social emotions. These are emotions which relate to care and companionship from within relationships, such as pain of separation and joy of connection.
* The child develops into a state of chronic defensiveness; defending against the real and anticipated pain were the child to be open to social engagement. As the social pain system is inhibited the children can experience blocked empathy.

When children experience blocked trust they:

* Learn to resist authority and to oppose parental influence.
* Avoid the parent as a potential source of comfort.
* Can’t relax and enjoy playful moments.
* Can’t be open, able to share thoughts and feelings.
* Remain vigilant to danger, with reduced curiosity and learning
* Don't trust in their parents' good intentions.
* Don't trust in the unconditional support and love that's on offer to them.
* Trust in themselves rather than others.
* Develop controlling behaviours as they try to take charge of their own safety. It feels safer to be in charge than to be influenced by another.

**DEVELOPMENTAL TRAUMA: IMPLICATIONS FOR INTERVENTION**

1. Safety
2. Self-regulation
3. Self-reflection
4. Traumatic experience integration
5. Relational engagement
6. Positive Affect Enhancement

**Domains of Impairment in Children Exposed to Complex Trauma**

1. Attachment
2. Biology
3. Affect Regulation
4. Dissociation
5. Behavior Control
6. Cognition
7. Self-Concept

“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.” (Van der Kolk, 2005, pp.407-408.)

**Six Core Components of Complex**

**Porges (2017)** also emphasizes the importance of safety:

**Trauma** **Intervention[[2]](#footnote-2):**Safety is prerequisite for strong social relationships.

Create safety through:

* Face to face social engagement, involving facialexpression,gaze and prosodic features of vocalization.
* Reciprocal interactions, involving facial expressions, vocalizing and listening.
* Play; allowing co-regulation of physiological state.
* Physical contact (eg hugs) while immobilizing without fear; provides connectedness. This supports health, growth, and restoration via physiological state.

Success when:

* Safe to cuddle and immobilize in arms of another.
* No longer vigilant about activity from behind.
* Social engagement not defence.

**Summary of DDP Intervention Principles matched to Trauma Literature**

* The experience of **safety.**
* Experience different relationships from original ones, including experience of safe **touch** from parent **(Social/Relational Engagement).**
* **Social engagement** involves face-to-face interactions with attention to facial expression and vocalization.
* **Playfulness,** experience joy in relationship and mutual experiences of fun.
* Provide opportunities for new consistent, predictable and frequent experiences that reduce associations built around the trauma, and reduce **hypervigilance**.
* Help child become **physiologically and emotionally regulated.**
* Help child develop improved emotional regulation abilities **(Self regulation).**
* Provide measured exposure to traumatic memories to help with integration of past traumatic experiences, including making sense of the impact of neglect and emotional harm (**Traumatic Experience Integration).**
* Provide emotional and cognitive processing leading to the development of a coherent narrative.
* Help children learn how to reflect - make sense of their thoughts, feelings and behaviours **(Self Reflection).**
* Help children experience and feel good about positive emotions **(Positive Affect Enhancement).**

**INTERSUBJECTIVITY**

An intersubjective relationship is a contingent and responsive relationship which allows each person to discover what is unique and special about the other and share this understanding together. How we see ourselves, our very sense of self, is an outcome of our intersubjective relationships.[[3]](#footnote-3)

**The Attachment relationship** is **one-directional.** ‘I look to you for comfort and safety’.

**The** **Intersubjective relationship** is **reciprocal.** ‘I influence you, I am open to your influence.’

**Three components to intersubjectivity**

**Matched Affect (Attunement)**

**Joint Attention**

**Complimentary Intention**

Attachment theory and intersubjectivity theory are closely linked. Dan Hughes refers to the way they are connected as “the double helix” (borrowed from understanding of DNA). Safety and intersubjectivity are interwoven. When safety is experienced **exploration** can follow. Within the context of safety, intersubjective exploration becomes possible. Through intersubjective exploration, attachment security is enhanced.

**Primary Intersubjectivity** (Trevarthen, 2001): The infant and parent discover each other in a reciprocal relationship and in the process discover more about themselves. The child develops a sense of self, reflected in the responses to her from the parents.

**Secondary intersubjectivity** (Trevarthen 2001):  The child learns about the world of people, events and objects. Child and parent together focus their attention outwards. This shared attention helps them to explore the world and learn about the impact of this world on each other.

The child learns about the world through the meaning the parent gives it. As the adult helps her to make sense of the world she develops the capacity to think. In this way children learn that the world, themselves and other people make sense. This in turn allows children to reflect upon, process and learn from experience.

**Implications for Interventions**

Intersubjective: reciprocal, comfortable influencing and being open to influence.

Lack of intersubjective experience: shame and social defensiveness. Need to take control of relationships rather than be open to mutual influence.

Autonomy without reciprocity = controlling behaviours towards others.

* Children who experience neglect lack early intersubjective experience. They feel not special and not loveable.
* Children who experience anger, fear or rejection experience terror and shame. They learn to avoid intersubjective experience.

Living with alternative parents, the child continues to avoid intersubjective experience and this can impact on the parents’ beliefs about self as a parent – feel that they are failing as parents and therefore do not feel safe with the child. They too withdraw from intersubjective experience.

The focus of interventions therefore is to help both child and parent feel safe enough to enter into an intersubjective experience.

**ATTACHMENT THEORY[[4]](#footnote-4)**

* Children are born predisposed to seek security from their primary caregivers. Fear, anxiety, tiredness, hunger, pain increase attachment behaviour in the child
* An attachment is formed which allows the child to seek security and comfort from the caregiver, and ensures the caregiver offers nurturance to the child.
* The caregiver or parent is therefore a secure base for the child.
* From this secure base, the child moves outward to explore and learn in the world, coming back to base again as needed.
* The child therefore has a range of **attachment behaviours** that signal to the parent that they need comfort, and a range of **exploratory behaviours**, which signal that they are ready to investigate the world around them.
* The child forms an internal working model; a template or memory of the relationship is formed. This will be a guide for the child both in the present and with future relationships.

For secure attachment to develop both the following are necessary:

**Consistent care-giving behaviours from adult**

**Care-seeking behaviours of the child**

Child learns to trust that the caregiver will provide for him, and learns that he has the ability to engage the caregiver and receive warmth and comfort in return.

The primary caregiver facilitates the attachment process by consistently meeting the infant’s emotional needs through touch, eye contact, smiles; and physical needs for food and safety. When the caregivers’ initial response is not quite right or if they fail to respond, the caregiver then repairs the relationship, reconnecting with the child.

**Attachment in a Nutshell**

**(**Slightlyadapted from the writing of Robert Spottswood, August 2015)

John Bowlby defined the infant attachment response in the 1950s as an innate survival mechanism that helps the child attract and hold the attention of an adult - an infant's only hope for survival. Bowlby, taking a different perspective from his psychoanalytic colleagues, stated that attachment is about survival instead of about love.

Infant humans generally arrive with the ability to smile, wave, coo, eye gaze, and we adults are hardwired to respond with proximity and mirroring behaviors. “*Ooh, are you talking to me, you’re so cute?*” This normally gives the child an early sense of agency (I can make something happen!). It also begins a preverbal relationship based in intersubjective connection and sharing which hopefully provides both physical care and dependable access to safety and pattern exploration. (Humans are born pattern-dependent organisms, important for learning to predict events.)

The best outcome from attaching to a nurturing adult includes:

1) the child's internalization of a “secure emotional base” from which she can grow to enjoy school and a lifetime of learning, and

2) the child's building a “positive internal working model” view of herself and her world (i.e., “I am good”, “My parent likes me”, My world is safe”)

However the children who end up in our helping programs and supportive agencies generally do not emerge from infancy with the best outcomes. Thus our understanding of what is optimal can help us find some measure of empathy for what they have been through. It can help us see their behaviors as making sense, in a coded sort of way, of their own experiences.

**Patterns of Attachment**

**Organized Patterns of Attachment**

A child can organizetheir attachment behaviour to feel cared for.

If care-giving styles are consistent, even if they are inappropriate, children can work out how to get a response from their parents. They can get their needs met.

If insecure these children will be able to form relationships that function in some ways. However, they will also develop unhelpful core beliefs, coping strategies and ways of managing their emotions.

Secure pattern of relating

Insecure patterns of relating

Inability to selectively attach (no-one to attach to)

Control via coercive behaviours.

Control via self -reliant behaviours.

Compliance, caregiving, aggressive.

**Disorganized-Disorientated Attachment**

Unable to organize behaviour to feel safe.

Highly **disinhibited** pattern of relating

Failure of attachment. Socially indiscriminate. Fail to use parent as secure base.

# Avoidant Attachment

Feel safer minimizing displays of emotion. Keep parent close by not displaying need. Fail to elicit care.

**Ambivalent-Resistant Attachment**

Feel safer maximizing displays of emotion. Resists being soothed or comforted. Fail to elicit support for exploration.

**Controlling Attachment**

When older controls relationships in order to feel safe.

Highly **inhibited** pattern of relating

Withdrawn, difficulty relating to anyone.

**Secure Attachment**

Straightforward in eliciting care, or support for exploration*.*

Frightened within relationships

**Disorganized pattern of attachment**

Children who receive frightening parenting may not find any ways of behaving that consistently work to get their needs met. Parents are frightening or frightened when child needs them most. Haven of safety is source of fear.

Non- Attachment.

Lacks consistent caregiver early in life. Severe neglect because isolated from caregivers; or multiple caregivers providing insufficient care.

**Behaviours that develop when attachment experience is developmentally compromising:**

* The absence of an apparent attachment strategy
* Elements of both avoidant and ambivalent attachment behaviours
* Freezing, stilling, apparent switching off - dissociation
* Dysregulation - easily overwhelmed by any strong emotion
* Abnormal body movements
* Direct evidence of being wary or apprehensive of others
* Hypervigilance

**Factors that may impair secure attachment**

1. Neglect of physical or emotional needs eg food, attention, caregiving.
2. Physical, sexual or emotional abuse, including domestic violence.
3. Frequent moves and/or placement in foster care, adoption or changes of family care.
4. Sudden or traumatic separation from caregiver through death, illness, hospitalization, or removal of child from family home.
5. Chronic mental health problems or substance misuse in caregivers, unable to provide consistent care.
6. Illness or pain that cannot be made better by the caregiver, invasive and painful medical procedures and/or lengthy hospitalisation

**UNDERSTANDING SHAME**

**1. Attunement** Emotional connection. Child and parent share and enjoy positive emotional states. Parent supports negative emotional states.

**2**. **Limit-setting, discipline** State of attunement is abruptly broken. Child experiences shame, an unpleasant emotional state.

**3. Interactive repair** Parent helps child manage feelings of shame and conveys continuing love and acceptance of child.

Child develops capacity for emotional and behavioural regulation and learns to express appropriate and inhibit inappropriate behaviours.

Shame is an affect, a complex emotion that develops later than the development of more straightforward feelings or emotions such as anger, joy or sadness.

Shame is uncomfortable for children and therefore children will learn to limit shame-inducing behaviours. In this sense it is protective, because it helps children to behave in a way that is safe, socially acceptable and helps them to develop relationships. This experience of shame is therefore integrative.

* For children with insecure attachment relationships the experience of shame is disintegrative.
* They do not experience the attunement- shame-re-attunement cycle but instead they experience unregulated shame that overwhelms them.
* Many experiences of disintegrative shame lead to shame becoming part of the core-identity. I am a shameful person. This person becomes chronically angry and controlling of others.
* When children have not had the experience of appropriately graded doses of shame, and the support and reassurance needed to help them to manage this, the shame engulfs them.
* They feel alienated and defeated, never quite good enough to belong. Children are trapped in shame. They feel abandoned and the shame becomes toxic.
* This leads to a state of development within which children experience difficulty both regulating emotion and thinking rationally. Children are left unable to respond flexibly or to control impulses.

**1. Little experience of attunement** Child does not experience emotional states shared or supported.

**2**. **Discipline occurs with**  Shame is excessive.

**rejection, humiliation or anger**

**3. No or delayed interactive repair** Experience of shame is not integrated. Child unable to develop capacity for regulation. Child develops sense of self as bad.

SHAME AND GUILT

Child behaves inappropriately.

# Eg is rough with the dog

Parent provides boundary.

*“You mustn’t hurt the dog.”*

Child experiences **SHAME.**

Goes quiet, looks away, makes self smaller, hides self

Parent comforts child and regulates shame.

*“I still love you unconditionally”*

Child notices effects of behaviour on others.

Feels **GUILT** for hurting another.

Development of **EMPATHY**

Shame and Guilt

Parent supports child and shame reduces.

Child experiences feelings of guilt, but this is about my behaviour not me.

Child looks outward:

How does the other person feel?

Accepts responsibility and feels sorry

Motivated to make amends.

= Freedom to learn from mistakes

**Shield Against Shame**

Shame without guilt

Child is unsupported.

Shame gets bigger = **Toxic Shame**

Child experiences feelings about self, looks inward.

I am bad, worthless, and stupid.

Denies shame, stops feeling it.

Cannot think about other person, accept responsibility or feel sorry.

Does not develop feelings of guilt, not able to make amends.

Weak development of empathy



**Minimize**

*‘It wasn’t so bad’*

**Lie**

*‘I didn’t* *do* *it’*

**Blame**

*‘It’s his fault’*

**Rage**

*‘You always blame me’*

*‘I’m rubbish’*

**GOALS OF DDP**

Primary Goal is to build a relationship with client/clients

The relationship is the healing.

1. Establish feelings of safety and security.
2. Co-regulate Affect.
3. Co-construct meaning of experience, present and past.
4. Help parent and child engage in direct communication with each other using A-R dialogue and PACE.

This therefore relies on interpersonal communication within intersubjective dialogues, modelled by therapist and then being used within families. Open and engaged stance facilitating social engagement instead of defense.

Use:

1. Affective-reflective dialogues.
2. Attitude of PACE.

In creating an affective-reflective dialogue the therapist has to atten to various things:

* Attunement - Connect and Chat (establishes rhythm).
* Follow-lead-follow.
* Attending to verbal and non-verbal, noticing discrepancies.
* Interactive repair – noticing ruptures and repairing them.
* When to intensify and reduce affective experience for the child.

With this approach healing occurs:

1. Through new meanings of events emerging from a dialogue within which experiences of events are explored with PACE. New meanings tend to have less shame, anger, doubt, fear, isolation, avoidance and hopelessness. Symptoms reduce. Safety increases, and openness within family increases to explore experiences.
2. Leading to increased attachment security and development of coherent narratives as dialogue generates new experiences of events. Often leads to change in interaction patterns within family.

**Children need:**

* Connections with others and unconditional love.
* Security of attachment to one or more people (culture dependent).
* Experiences of intersubjectivity.
* A context within which to become socialized and develop their reflective function.

**Developmentally traumatized children** often need to learn to survive without safety, security or connection.

* Children may take control and fear other ways of being.
* They may avoid intersubjective experience. They may not want to connect, as they fear that this will only confirm what they already know. This may include core beliefs such as *“I am not lovable”* or *“Adults always let me down in the end”.*

**DDP PRINCIPLES**

**Developing the intersubjective relationship – affect (attunement), attention, and intention**

In this shared state, individuals have the most influence on each other. One key part of learning how to practice DDP is learning about each of these and making sense of how they combine and join with each other.

How can I do this?” is a key question and one that is central to practicing DDP**.** It is more than sharing information or being curious or giving what you feel might empathy. It is sharing inner experience; two people connecting their inner lives.

One goal of DDP is to let the child (or parent in parental consultations) clearly see that they have a positive impact on you and how they affect you. This is not about practitioners being “genuine” and telling people how angry they are with them for not trying or that the parents are too self-absorbed, or the child is too rude. It is about discovering a person’s strengths (which the practitioner responds to with delight and recognition) and vulnerabilities (which are responded to with empathy and compassion).

**1. Attunement** (Dan Stern, 1985)

Attunement begins when the parent provides the infant with an experience of emotional connection with another that is consistent and provides contingent responses to her communications and needs. An attuned response is therefore an empathic response that helps the child to feel understood and connected to the adult. The child learns to trust in the availability and responsiveness of the adult. Attuned responses can include the adult matching the child’s affect.

**Application of theory to practice**

Attunement represents the sharing of affect intersubjectively, which leads to the co- regulation of affect - one of DDP’s core components. This in turn supports the development of the capacity for reflective function

**Link to emotional regulation skills:** By feeling connected to the parent the child co-regulates her affective state with that of her parents, thus developing capacity for emotional regulation and improving reflective functioning. When matching of affect or attunement is lacking in relationships, the risk of mood disorders, increases, such as anxiety or depression.

**2. Joint Attention**

For individuals to be intersubjectively present, they need to be focused on the same content. In this context, attention is a more active focusing of your awareness rather than simply being aware. This could include something in the present being experienced together, something from the past being shared by one person that the other had not experienced, or something that is being remembered together.

It may not be hard to achieve joint attention through a non-directive stance, when an individual has motivation and ability to explore difficult themes. It can be really difficult to achieve with individuals who have developed patterns of avoidance regarding attending to events that are experienced as stressful. The skill for the parent or practitioner is in learning how to actively maintain the joint focus on an event so intersubjective experiences of it can be explored.

**Link to difficulties with attention**

When sharing of attention is lacking in relationships, such as when a parent is preoccupied with her emotions and thoughts, children may not learn how to regulate their attention. The risk of attentional difficulties increases, such as ADHD and ADD.

**3. Complimentary intentions**

For individuals to be intersubjectively present, they need to want similar things from their time together, although they may take a different perspective to achieve it.

Such intentions are reciprocal (joint, shared, mutual) and may be changed as dialogues develop. Cooperation can be defined as being engaged in activities where the individuals hold complimentary intentions. In DDP, practitioners make their intentions clear as well as their experiences of the child and/or parent in the room.

**Link to oppositional and defiant behaviour**

When there is a lack of complimentary intention or shared goals in relationships, such as when a parent is preoccupied with her own needs and interests, this increases the risk of oppositional and defiant behaviour, such as conduct disorder.

**Application of theory to practice**

Experiencing Joint Attention combined with Complementary Intentions helps with the development of reflective functioning which further enhances emotional regulation

* Parent and child jointly attend to who or what is important to them. They share an intention to notice, discover and enjoy each other or an event or object in the world.
* By jointly experiencing each other and the world, the child learns to think about her own mind and the mind of others.
* This leads to the development of reflective functioning; this includes the ability to understand why things happen and why people behave as they do. It is the beginning of developing an awareness and interest in the mind of another person, who has a separate and different mind from oneself. It leads to empathy. This in turn impacts on the capacity to emotionally regulate. The development of reflective functioning and emotional regulation are closely connected and supported by the intersubjective relationship, with all three components contributing to this.

**Connect and Chat**

The goal of a DDP session is to get to know the child (or parent). The intersubjective relationship is central to this process. Connecting intersubjectively with some light talking can help a child to settle into a session. The practitioner can notice when the child introduces more difficult themes that can be explored more deeply. (Sometimes such themes are introduced by the parent, or the practitioner). The child experiences the same light tone, interest in them and non-judgmental attitude when exploring the deeper themes as when chatting about lighter themes. Adopting a story telling tone helps to maintain the engagement with the child.

**Safety and security**

If there is lack of safety either for child or parents this has to be attended to.

**Parent safety** comes first, so that they can provide safety for the child. This might need individual sessions with parents, or spending time with them alone at the beginning of a session. If there is a lack of safety during a session, and the therapist can’t move the parent quickly then it is important to stop the session. Explain to the child that mum/dad is feeling angry right now, you need to help them with this at the moment.

**Child safety**. Help child to feel safe with you and use this relationship to help them to increase feelings of safety and security with the parents. Relationship is the primary means of safety, but you can also establish some feelings of safety through structure, routine, and activities.

Children who have experienced developmental trauma will have great difficulty feeling safe. Neither will they turn to current parents for safety. They will stay hypervigilant, hypersensitive and hyper-reactive. They will not trust the intentions of adults, having little confidence that they want what is best for them. The therapist needs to continuously monitor the child’s verbal and nonverbal communications as to whether or not they reflect safety or its absence. When the child is experiencing lack of safety, the therapist can:

* Accept and acknowledge the child’s distress with PACE.
* Change the focus to a less threatening theme.
* Take a break by talking with the parents for a time with no expectation on the child to respond or participate if he would rather not.
* Engage in some joint activities that will help the child with regulating his affective state.

**Co-regulation of affect**

* The co-regulation of affect is one of the central goals of DDP. This process helps with development of emotional regulation and reflective functioning

The child’s affective response to the experience is being co-regulated by the therapist’s affective response. As the therapist responds to the child’s affective states, nonverbally and verbally, they mark the affect with an empathic, congruent response. This helps the child to create a secondary representation of the original affect and leads to the capacity for reflective thought (see Fonagy et al, 2002).

* Affect is defined as the non-verbal or bodily expression of either a specific emotion or a milder, more general sense of content or discontent. Affects are conveyed (following what Dan Stern refers to as “vitality affects) through the intensity, rhythm, beat, duration and shape of bodily expressions, which include facial expressions, gestures, movements and voice prosody (i.e. intensity, vocal pitch, rhythm, rate of utterance). Prosody overlaps with emotion in speech. The same features that are used to express prosody are also affected by emotion in the voice. For example, it is possible to be simultaneously fearful and sarcastic.

**Co-creation of meaning**

This means developing a shared meaning of experiences, behaviour and events, past and present that the child understands, makes sense of and could tell as their story, should they choose to do so. It is crucial to be able to tell a clear story about your life - your memories, experiences, and emotions - including the good and the tough times and share it with someone else. This helps to define who you are and to make sense of your feelings and your responses.

**Establishing a clear coherent narrative.**

* Use affective-reflective dialogue (see below) and keep it connected to the present. The integration of the verbal and non-verbal components of the dialogue is crucial for the development of the narrative, linking to storytelling as described below.
* Supplement with non-verbal approaches if helpful, eg drawing on experiential activities such as drawing, puppets, theraplay activities etc.
* Content will be emotional and reflective as new meanings of events are developed together.
* It can be helpful if the child is physically close to a safe primary attachment figure during exploration of difficult parts of his story.
* The child’s attention is held by the practitioner’s and/or parent’s non-judgmental, attentive and curious stance.
* The parent and practitioner may need to suggest tentative words, arising out of known facts and their experience of the child so that the child can gradually identify and more fully express his or her inner life.
* Through the intersubjective process the child co-constructs the meaning of his experience.
* The child integrates the meanings given to the experience through the interwoven perspectives of parent, practitioner and self.

**PACE**

An attitude that the therapist and parent hold, which creates safety and security and helps them to maintain emotional engagement with the child.

* **An open, spontaneous playful (P) stance.** Uses a story telling voice and light voice tone. Can help the child to stay with the intersubjective experience. Adds elements of joy, enjoyment, pleasure, fun and hope.
* **Provides consistent acceptance (A) of the child’s internal experience**. Includes his thoughts, feelings, wishes, motives, perceptions and the underlying reasons for his behaviour. Creates psychological safety. Behaviour may still require discipline limit setting.
* **Demonstrate active, non-evaluative curiosity (C) about the child’s experience of events.** Wonder why the child might be behaving or feeling as he is. Creates psychological safety.Child is less likely to feel cross or frustrated, and become defensive because it is non-judgmental. A stance of wondering, sometimes tentative, always curious, without anticipating a response. It helps child to be more open to intersubjective experience of self, others and events. Curiosity leads to understanding.
* **Provide the child with empathy (E) towards his experiences. and support**. Make sense of and experience the internal world of the child and how they experience what is happening. Show this actively so you demonstrate with your words and your non-verbal behavior that he has an impact on you, and there is no ambiguity as to how he has an impact on you*.* Child experiences practitioner and parents as with him as he explores past and current experience.

Communication using an attitude of PACE increases the likelihood of the other person staying open and engaged to whatever is being discussed. It increases the likelihood of both individuals making an emotional connection. It reduces the likelihood that the other person (or you) become defensive, irritated, or distracted. The other person is less likely to ignore, avoid, become hostile, switch off or walk off.

**Affective-reflective dialogue**

Affective-reflective dialogue, the core of DDP, is an integrative activity that involves:

* The emotional meaning of an event or experience
* The affective expression of an event or experience
* The cognitive understanding of an event or experience
* How the event or experience fits or is made sense of within the individual’s reflective awareness.

The “Affect” of A-R Dialogue builds safety so that the “Reflect” of A-R dialogue (the co-creation of meaning) can occur. Whenever the exploration of meaning generates shame, fear, sadness that might become dysregulating, the exploration stops and the focus is on establishing safety through, for example, co-regulation of affect, taking a break, using “Talking About”.

When the process of A-R dialogue becomes established as the primary way in which family members communicate at home, and/or in therapy, conversations about previously stressful events or experiences are more likely to be shared, understood and safely integrated within the narratives of those involved. Communicating about important content before this process is established, especially if the content has stressful associations, is likely to make it difficult to sufficiently address and integrate.

**Making Sense of Behaviour - Behaviour as Communication**

**Under the behaviour:** You need to do the best you can to make sense of the underlying intentions, thoughts, feelings, wishes, perceptions of the child. This will also involve understanding what coping strategies the child developed, needed at the time for survival.

This helps with the development of the Acceptance component of PACE. The Curiosity component of PACE can help with this; express an authentic interest through wondering “How come…?” this or that happened. Think about how interactions are currently made sense of. Look at what is driving the child’s behaviour - what reaction or response might the child have anticipated from the other person?

**BEHAVIOUR AS COMMUNICATION:   
EXAMPLES OF VERBAL RESPONSES**

**Examples of responses to children’s behaviours, with an emphasis on Curiosity**

“I’m interested in how it could be that you find it so hard to look at me…. when I tell you how well you have done?”

“I wonder why you felt you had to throw your friends book into the mud?”

“How come you get so angry with me when I ask you to write the title?”

“I wonder what it’s like, to hear your dad say that about …”

Enable the child to give feedback and let you know if you are wrong:

“I’ll guess - you let me know if I am wrong”….

“Help me find of way of knowing when I’ve got it wrong”

**Examples of responses, with an emphasis on Empathy**

“You seem a little sad now.”

“You look really upset at what she said.”

“It’s scary sometimes when you have to …”

“It’s sad that even after all this time it’s hard for you to trust me enough to …..tell me when you have had a tough day at school….tell me the truth.”

“You seem to be finding writing that essay really hard.”

“You seem pleased that you made that choice.”

“You seem angry with me. I wonder if you think I said you couldn't go out because:

I’m being mean,

I don’t really care about what you want.

I don't really get how important this is to you.”

“I see you’re happy about …”

“It seems so hard for you.”

“No wonder you don’t feel like going to school today…”

**Putting it all together**

“You know, sometimes I wonder if you steal things to remind us that once your life was very different. Maybe sometimes (you think) we forget this.”

“You know the last time I saw someone do that they were very scared about….”

“Your life has been so hard –so many people have let you down, no wonder you’ve given up on getting close to people”

“My guess is …. that you are so fed up about your dad being late picking you up from school, that it is easier for you to ... than to talk about what it feels like to be let down again.”

“No wonder you feel so sad …or hurt, or bad, if you think your mum loves your brother more than you. Maybe I can help you with this in some way.”

For any of these responses to be effective, the responses of the parent and practitioner need to communicate acceptance, empathy, curiosity, and when appropriate gentle playfulness.

They are not effective if they are used with sarcasm, which can sometimes be a parents’ response to concerning behaviour when they start to practice responding with PACE.

**DDP AS IT HAPPENS**

**Storytelling**

To hold attention therapist or parent can’t lecture, reason or problem-solve.

**Lectures:** attempt to get child’s attention, but lectures don’t hold attention. Child will become defensive and angry. Elicits frustration and possibly shame which reduces attention. Lectures are aimed at controlling or influencing the child but are not receptive to being influenced by the child.

**Problem-solving**: similar to lectures but without the ‘should’ so clearly implied. If the focus is only on the symptoms, there is too much problem-solving. Problem solving should be limited and following more extensive exploration of experience. Ie after emotions have been explored and meanings of interactions clarified and communicated.

**Story telling**: Children will listen to stories.

* Storytelling – rhythm, suspense, holds attention. Non-verbal and verbal, pulls child into story.
* Move from storytelling on neutral topic to more pertinent topic – but voice does not change ie maintain storytelling style.
* Notice child’s response, and talk about this in same storytelling way. Use enthusiasm, pausing, wondering, build suspense and drama.

Generates safety, deep interest and momentum leading to increased coherence within the story being created. Reduces likelihood of defensiveness or avoidance when new events come into the storytelling process. Ie increases reflective function.

**Follow-lead-follow**

Not directive nor non-directive.

Start with non-directive: **Themes** are presented in the course of talking with the child and the family. These might be introduced by the child, parent or the therapist. Therapist follows the theme and then leads into a deeper AR exploration; following the child’s response to this.

With very active children the therapist might need to begin with lead and then follow. Lead into themes that seem related, or those relating to particular difficulties. Follow client’s response to these.

Two general themes tend to dominate:

1. The trauma and its effects. This occurred prior to living in the present home.
2. Child’s experiences and behaviour in the current home.

Some children have more fear and shame associated with the first, others the second. Therefore, the therapist needs to lightly touch on each in the first session. Assess child’s responses to see which appears easiest to address. Focus on this theme first.

**Verbal-non-verbal**

When verbal and non-verbal match there is a deeper and more open communication. Discrepancy between verbal and non-verbal is noticed and made sense of.

**Rupture and repair**

Repair is the adults’ responsibility; apologise when things go wrong. Behaviour must not be seen as more important than the relationship. A lack of relationship repair within the family needs to be understood and facilitated if necessary. When repair is missed families become locked into cycles of escalating conflicts or patterns of avoidance. Repair is the responsibility of the parent, communicates that relationship is more important than any conflict.

**Communicating with, for, and about the child.**

Facilitating communication with the parent is important as it helps the child to experience security and intersubjectivity.

**Parent- child communicating** is therefore a goal of the work. The parent witnesses the dialogue between therapist and child. It is important that the child directly experiences this witnessing so they are not left with worries that parent perceives them as bad in some way. Therefore, help the child to let the parent know what he has discovered and how he is feeling. This will intensify the affective experience of the child, supported by the parents.

The goal is for child to **talk to and with the parent.** If the child can do this, then the therapist just encourages him. When the child is not yet able to do this the therapist can:

**Give words to the child:** The therapist helps the child to talk to the parents by giving him some words to say, based on the story they have been creating together. These are the child’s words discovered in their joint exploration.

**Talk for the child:** The therapist talks to the parent as if he is the child.

If the child is at his limit for emotional experience the therapist can help him be a witness to the story they have been creating together. This will reduce the affective experience for the child whilst still allowing him to see his parents’ response. This is:

**Talking abou**t; a more reflective stance which gives a break from the deepening affect.

**Discovering Comfort, Curiosity and Joy**

Sadness is the hardest emotion to experience for traumatized children.

They are afraid to feel sad, anticipating no comfort.

Help child to feel safe to be sad and to become open to comfort again; to be able to cry in parent’s presence.

Need to recover the capacity for sadness

Trauma destroys curiosity; novel is threatening, new or different is feared.

Child is defensive.

Help child to become open and engaged. To experience it being safe to be curious and share in a state of wonder.

Need to recover the capacity for curiosity

When children fear and resist relationship, they cannot experience joy within relationship.

Help child to shine in the delight of the other and to mirror your joy in being with them.

Need to recover the capacity for relational joy

**SOME GUIDELINES**

1. **Lighter before more difficult themes**

A session generally begins with lighter and more positive themes (unless the child brings up something difficult herself). This establishes a storytelling rhythm and momentum that can then be used when the focus moves towards more difficult themes. It also avoids beginning with difficulties. Try not to ask how things have been as that can move into problems.

1. **Talk about the elephant in the room**

The therapist notices and addresses specific thoughts, emotions, wishes, memories or other aspects of family members’ view of self, other and family that are not welcome into the narrative. This is generally noticed by the lack of congruence between the verbal and non-verbal.

1. **Accept resistance**

Resistance generally means the therapist is going too fast. Accept resistance, and slow down. Resistance signals the need for a break when the content is too stressful. The therapist needs to step back from it, focus on immediate experience and co-regulate affect.

1. **Work with parents**

As well as working with the parents before the work with the child begins, it is important to allow time for this as the work is progressing. The balance between working with child and parents and parents alone will need monitoring and adjusting flexibly according to need.

1. **Use of Touch**

Safe touch is crucial in human development and essential for the building of security of attachment. If you can touch hyperactive children, they will calm down much more quickly. Look for opportunities for parents to touch their children, but do not use this as a technique eg don’t use a hug or touch to make something exist which doesn’t exist. Touching needs to be natural and spontaneous, and should never be used coercively except as a final resort at times of danger.

**WORKING WITH PARENTS[[5]](#footnote-5) AND CAREGIVERS**

Work with parents can include:

* Stand-alone parenting interventions
* Consultation, support and preparation before therapy
* Consultation and support alongside therapy. This includes contact (either face-to face or by telephone) with the parent coming with the child, before each therapy session, and sometimes after a therapy session. It also includes regular review meetings alongside therapy.
* Consultation and support after therapy
* Working alongside parents in network or “team around the child” consultations

If there are two parents, this approach involves both parents in therapy and consultations whenever possible.

Parents are asked to carry out many difficult tasks both in parenting and as a crucial part of this therapeutic approach. Parents may also have their own experiences that are being triggered by some aspect of caring for their child. Time to explore these with the therapist is an essential part of the work.

As with the child it is important to explore the parents’ experience rather than moving too quickly to try to fix the problem. Parents will also need time to reflect on their own experience, and the impact the child is having upon them, before being ready to reflect on the child’s experience. If parents are stressed and exhausted acceptance and empathy for their situation is essential before attempting to provide them with yet more parenting strategies to try, or to ask them to start using PACE at home, or to start therapy with them being actively involved.

For the purpose of increasing the child’s psychological safety, his readiness to rely on significant attachment figures in his life, and his ability to resolve and integrate the dysregulating experiences that are being explored, a person who is an important attachment figure to the client will be actively present.

The role of the parent, or other attachment figure, in her child’s therapy is to:

1. Help him feel safe.

2. Communicate PACE, both nonverbally and verbally.

3. Help him to regulate any negative affect e.g. fear, shame, anger, or sadness.

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

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

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

7. Help him to understand his parents’ perspective and motives with respect to him.

Hughes, D, *Meeting the Psychological Needs of Fostered and Adopted Children and their Families*. Paper from conference at Islington Town Hall, London, UK. 11 February 2011

**INITIAL AIMS OF WORK WITH PARENTS**

1. Increase the opportunity for parentsto develop safe and close relationships with those who are supporting them, with practitioners who can be involved for long periods. Safety is increased if practitioners can be clear about their role from the start, as well as how long they can remain involved.
2. Help parents consider, develop and maintain self-care.
3. Help parents consider and develop their self-regulation and reflective skills.
4. Enable parents to begin to trust the adults who provide support. To know that this help will be accepting and non-judgemental as to their internal world of thoughts, feelings, beliefs, motives, perceptions; for example, believing their child hates them. At the same time unhelpful or potentially harmful behaviour toward their child may need to be directly addressed. As with children making a connection first is crucial.
5. When parentshave developed some security in these relationships, they may then be able to address relevant issues without being defensive, feeling threatened or overwhelmed.
6. Then provide opportunity for parents to consider, make sense of and manage the impact of caring for their child now and in the past. They may have had little support to make sense of their child’s troubling or challenging behaviour previously, or past support may have been experienced as unhelpful or as not making a difference.
7. If relevant, provide opportunities for parents to make sense of and manage the impact arising from their own relevant early childhood experience of being parented. Include the impact of any past emotionally, physically or sexually abusive relationships with partners or peers.

If the above aims can be met, this will increase capacity for parent’sreflective function and emotion regulation in the face of their exhaustion, high stress and often self-critical stance about their own parenting or about the help offered by others.

**Preparation with parents for therapy**

Living with alternative parents, the child can avoid intersubjective experience and this can impact on the parent’s beliefs about their effectiveness and abilities as a parent. They can feel that they are failing as parents and sometimes do not feel safe with the child. They too may then withdraw from intersubjective experience.

One focus of therapy is to help both child and parent feel safe enough to enter into an intersubjective experience. This can be worrying for parents who feel they are failing, or that their child doesn't love them. It is therefore crucial to work with parents about their own experiences of parenting, and of being parented, before starting therapy involving the child and parent in the room together.

**MAKING SENSE OF PARENTS’ BEHAVIOUR**

It is important to understand the parents’ experience, and behaviours, in the context of caring for a child who finds trusting adults hard and shows limited attachment behaviour.

Parents have often struggled, sometimes for many years, to make sense of how best to care for their child. They may have received other interventions that aim to help but aren’t experienced as helpful. When they start working with a DDP practitioner the parents may have already developed a range of behaviours that are unhelpful for the child. These might include: Chronic anger, harsh discipline, power struggles, not asking for help, not showing affection, difficulty sleeping, appetite problems, ignoring child, remaining isolated from child, reacting with rage and impulsiveness, lack of empathy for child, marital conflicts, withdrawal from relatives and friends, chronic criticism.

**Under the Behavior**

**Dan’s Three Assumptions:**

1. They are good people, not bad people
2. They are doing the best they can
3. They love their child or they used to love their child and want to get this back or they want to find a way to love their child

Just as with children, it is important to remain open and engaged, seeking to understand rather than judge. Look under the behaviour and work with the parents to try to make sense of how these behaviours and emotions have developed. Some reasons may be:

1. Being physically hurt by child
2. Parental fear of rejection by child
3. Parental fear of failure
4. Inability to understand why child does things
5. Inability to understand why self reacts to child
6. Association of child’s functioning with aspects of own attachment history
7. Feeling lack of support and understanding from other adults
8. Feeling that life is too hard. Assumptions that child’s motives/intentions are negative
9. Feeling that there are no other options besides the parenting behavior tried
10. Desire to help child to develop well
11. Love and commitment for child
12. Desire to be a good parent
13. Uncertainty about how to best meet child’s needs
14. Lack of confidence in ability to meet child’s needs
15. Specific failures with child associated with more pervasive doubts about self
16. Parental pervasive sense of shame
17. Conviction of helplessness and hopelessness
18. Fear of being vulnerable/being hurt by child

**Venting**

**Monologue** = not therapeutic. parent not left feeling better. Dismissive of the listener as a person, you are not having a reciprocal influence on them ie not intersubjective. Monologues may stem from a history of not being listened to or a way of not experiencing the emotion.

**Dialogue** = therapeutic. Therapist may be doing more listening, but with engagement and empathy Parent is left feeling understood, that you get it. Intersubjective.

When client is venting through monologue need to move from **monologue to dialogue**

Help them to vent appropriately. Interrupt them, matching their affect. Slow down with some repetition, then give empathy. Parent learns to **vent intersubjectively**.

**FOCUSING ON PARENT’S ATTACHMENT HISTORY   
FOR BUILDING MOTIVATION**

“ For a caregiver and therapist to remain present for a child during periods of dysregulation, it is important for them to have resolved any similar issues from their own attachment histories. The significant adults in the child’s treatment need to address - in their own lives - any areas of fear or shame that are similar to what they are asking the child to address.

Hughes, D, *Meeting the Psychological Needs of Fostered and Adopted Children and their Families*. Conference Paper, Islington Town Hall, London, UK. 11 February 2011

In providing psychological treatment for families, whether they be biological, foster or adoptive families, it is crucial that the therapist be able to maintain the same degree of empathy for both the parents and the children. In order to increase empathy, it is often beneficial to enter the subjective experience - with acceptance and curiosity - of the other. When the therapist has difficulty developing empathy for the parent, often it is the parent’s resentment toward the child and others that causes the problem.

When parental resentment is present at the first session it is important to allow the parent to express the depth of their frustrations and concerns so that they feel understood with regard to their current situation. It is then often helpful to go back in time with the parent to the beginning of the parent’s parenting history. When an adult decides to become a parent, parenting itself becomes central to her identity. Her successes and failures as a parent are likely to go to the core of the sense of self. We must turn our focus on that first moment in which an adult decides to become a parent.

1. **Hopes and Dreams**: As the adult decides to become a parent she immediately imagines a future relationship with her child. This is true for foster, adoptive, and biological parents. She may dream of parenting her child in a manner similar to, or different from, how she was parented. She may dream of the first time she will sing the child a nursery rhyme, shampoo her hair, buy her clothes and toys, watch her concerts and graduation. She anticipates the pride and joy she will feel as the parent of this developing person.
2. **Doubts**: At some point she begins to doubt that she will realize her parental dreams. This may come when her child shows difficulties that she cannot resolve. It may come when her child defies, criticizes or ignores her. Her initial response is most likely more of sadness or fear than of anger. What can she do to reawaken the dream?
3. **Grief and loss**: When the doubts deepen and broaden and begin to permeate many areas of her relationship with her child, she is gradually convinced that her dream will not come true. She first protests, then despairs over the loss of her dream. But she cannot resolve her grief—her protest and despair become repetitive.
4. **Shame**: An unavoidable conclusion gradually emerges: she has failed as a parent. Regardless of the reasons that she knows intellectually - past traumas and losses by abusive parents, RAD, FAS, ADHD, ODD, OCD, etc - she has failed.
5. **Resentment**: Pervasive, unresolved, shame has few outcomes that do not involve resentment. Possibly denial, minimalizing, blaming, and making excuses will be present. The parent may stop all affect in order to stop feeling shame. The parent may become cold and indifferent to reduce the resentment. Whatever defense/symptom the parent chooses, the therapist’s empathy is at risk.

**FOCUSING ON PARENT’S ATTACHMENT HISTORY   
FOR BUILDING MOTIVATION CONT.**

When the therapist and parent are able to explore these stages of the parenting history, there are many opportunities to build empathy and trust in the relationship:

* The therapist understands the context and history of the development of resentment.
* The parent remembers herself when she was motivated by hopes and dreams.
* The parent knows that the therapist knows how she was once motivated.
* The therapist and parent often explore aspects of the parent’s attachment history that were interwoven with her parenting history.

As a result of this journey into the past and the giving/receiving of empathy, the following process may now occur:

1. **Acceptance**: Being able to safely reflect on the parenting path toward resentment, the parent is able to achieve some acceptance of her parenting narrative.
2. **Commitment**: Through the experience of the therapist’s empathy and the emerging, integrative perspective, the parent’s shame begins to break. Often the parent is able to make an initial commitment to try again to be a successful parent.
3. **Realistic Hopes and Dreams**: Through reflection on the parenting history - knowing both self-and-child much more deeply - the parent is able to begin to create more realistic goals jointly with the therapist, and the child.
4. **Therapy in action**: Having successfully journeyed through the parenting history, the parent and therapist more deeply explore the attachment history. In the context of safety and PACE, the therapist is free to address, guide and recommend changes in the parent’s daily interactions with her child.
5. **Pride & Joy**: Successes increase and failures decrease. Guilt occurs without shame. A parenting history different from the original attachment history often develops. A coherent autobiographical narrative that includes being a parent emerges. Any continuing difficulties of the child are met with PACE, not parental shame and resentment.

**MOVING INTO ATTACHMENT HISTORY: A GUIDE**

Exploring the experience of parenting and how this is impacted upon by past relationship experiences. This allows some exploration of what strengths and vulnerabilities the parent brings to current parenting and how these can be triggered by the experience with the child.

Help parents to know that you ‘get it’. They are being heard and that their experience is not being minimized or judged. Listen to their anger and frustration

1. **Explore symptoms parents perceive in child**

Symptoms are motivation for parent coming, don’t minimize these. Explore how they have made sense of these. Find out what they have tried.

* Usually parents have good things that motivated them. As you explore this they build trust that you understand that they are good people. May also link to unresolved losses, also accept and have empathy for this experience, alongside curiosity about how it has impacted upon them as parents.

1. **Explore hopes and dreams**

Acknowledge that this wasn’t what parents were expecting. Explore hopes and dreams when they first decided to parent the child.

1. **Explore doubts and fears**

When did they start to think their dreams were not going to come true? This isn’t the child they thought they would be parenting. Parents are also likely to acknowledge fears, for example, that they are a bad parent, that they should not parent, that this is the wrong placement for the child etc. This will touch upon their feelings of grief, loss, resentment and shame

Accept their discouragement. Have empathy for this experience. This allows a re-exploration of symptoms but now with sadness and vulnerability. Leads to feelings of grief, loss, and shame. Empathy and acceptance leads to trust and feelings of safety.

1. **What is the hardest thing they find in the child to have empathy for?**

The ‘magic’ question. It often connects to their own attachment and other relationship history. What they can and can’t cope with can be surprising. By approaching history in this way, it embeds the exploration in the context of their current parenting.

* Help parent to see that you are not blaming them but are curious about their own experience and how it links with parenting.

Deepen exploration with questions about response to upset, separation, difficult experience. Ask parent to recall actual events.  
eg as a child how did you calm or comfort yourself when upset, ill or separated? As an adult how do you calm or comfort yourself?  
How has this experience impacted on your parenting?

1. **Explore strengths parents perceive in child**

This is something to build on, even if very small. See something good in the child. Increases acceptance and commitment. This can in turn lead to feelings of pride & joy: Successes increase and failures decrease. Guilt occurs without shame. Any continuing difficulties of the child are met with PACE, not parental shame and resentment.

1. **Explore attachment history**

Explore difficult issues, as this is likely to link to symptoms in child. Help parent to understand the feelings they have in response to the child, linked to this history. Understand their triggers.

This moves the discussion into a more hopeful dialogue. Helps the parent to understand the difficult impact the child can have upon them and to reach new and realistic hopes and goals

**BLOCKED CARE**[[6]](#footnote-6)

Continually offering a relationship without this being reciprocated by children who are in blocked trust can have a profound impact upon the parent. The parents’ caregiving systems, within the nervous system, are active as the parent tries to provide the experiences the child needs. However, it is stressful when the child consistently fails to respond with appropriate attachment responses, ie to be care receiving. The parents’ own caregiving systems become weak or unstable. The functioning of the caregiving systems in the brain are suppressed which moves parents into defensive responding and impairs their ability to attune to and connect with their children. In other words, the parents’ experience ‘blocked care’ in response to the child’s ‘blocked trust’. Hughes & Baylin describe the five brain-based caregiving systems which allow parents to care sensitively and responsively for their children.

**Approach:** The hormone oxytocin is released in parents to prime them for caring for their children. The parent can stay open and engaged with their children instead of becoming defensive. The drive to approach and care for the child is activated whilst the drive to avoid is deactivated. When caring for the child is very difficult less oxytocin is released and the drive to avoid is more likely to be activated.

**Reward:** Social engagement with the child leads to the release of dopamine. This sustains the caregiving process as the parent enjoys interacting with and caring for her children. This is a reciprocal process; each enjoys being with the other; the relationship is experienced as pleasurable. Where this reciprocal process does not happen there is less dopamine and thus no feelings of pleasure. This leads to disengagement.

**Child Reading:** The attuned relationship with the child facilitates the parents’ deep interest in the child, and a desire to make sense of his experience. The parents can use their powers of empathy and mind-minded abilities to understand the child’s feelings and needs. When the attuned relationship fails this empathy and mind-mindedness declines as the parents become defensive and thus are not open and engaged to the child’s experience. High levels of stress reduce mind-mindedness, reducing this ability to make sense of the child’s experience, parenting becomes focused narrowly on changing behaviour whilst empathy and compassion are reduced.

**Meaning Making:** Parents are drawn to make meaning of their experience with the child. At its best the parents will construct positive narratives (stories) about their children and about themselves as parents. This links with their past history of attachment and relationships. Ie we make meanings through the lens of past relationships. When the parent –child relationship is under stress parents tend to make negative meanings, as memories of past relationship stresses are activated. Under stress parents are more likely to hold negative narratives about their child or themselves which increase their defensiveness. Ie they may view their child as ‘bad’ or ‘naughty’ and/or themselves as failing.

**Executive system:** This is the integrative centre of the brain that co-ordinates the functioning of the brain, bringing together all its parts. The executive functions allow for integrated brain functioning so that cognitive and emotional parts of the brain work well together. These processes are responsible for guiding, directing and managing cognitive (thinking), emotional and behavioural tasks. Executive functioning allows purposeful, goal directed and problem solving behaviours. Parents can regulate their emotions and maintain a caring state of mind towards the child. This functioning is less dependent upon the child’s influence upon the parents. Executive functioning will reduce under stress but if the parents have developed reasonable executive function, they will be able to care for the child but without the other caregiving systems working well the joy in this parenting is lost. The parent does the job, but experiences no pleasure in this.

**BLOCKED CARE CONTINUED**

Blocked care can develop in a range of ways.

1. Chronic blocked care: This can occur when the parent has experienced very high levels of stress beginning early in life. In this case the ongoing stress means that the care system and the self-regulation system are poorly developed. Thus the caregiving process is difficult to activate and this combined with an underdeveloped executive system makes parenting attuned to the child’s needs very difficult.
2. Acute blocked care: This can occur when the parent experiences a period of more acute stress which he or she is finding difficult to cope with. This overwhelms the parents’ ability to cope and caregiving is suppressed. Support at this time is essential so that this temporary state of blocked care does not become more enduring.
3. Child specific blocked care: This can occur when a child has difficulties which mean that she does not respond in the way the parents are expecting, especially when the child does not respond in a positive, reciprocal way to the parents’ care of her. The violation of expectations leads to more defensive responding from the parents as they feel rejected by and/or angry towards their child. This results in blocked care. Parents can be especially sensitive to this reaction to a child if that child reminds the parent of someone in their past that they had a difficult relationship with.
4. Stage specific blocked care: Children and adolescents can go through stages of being more argumentative and less open to their parents’ caring behaviours. Some parents do well when the child is engaged and receptive to them but really struggle during these stages of more challenging behaviours, especially when they experience this as rejection from their child.

**Protection from, or recovery from, blocked care**

1. It can be helpful to start by helping parents to learn about blocked trust and blocked care. This psychoeducational foundation can help parents to increase their understanding and empathy for themselves and the children. This in itself can reduce blocked care as the parent understands why the child is rejecting and how this impacts on the brain.
2. The attitude of PACE and compassion to self allows the caregiving systems to work well strengthening these and improving integration between them. At times of stress the parents are able to avoid becoming defensive and remain open and engaged to the relationship. This can have a positive effect on the child who will also become less defensive and becomes more open to entering an intersubjective relationship with the parent.
3. Social support. Relationships, especially those offering PACE. Intersubjective relationships with trusted others can be very protective.
4. By developing and strengthening abilities to emotionally regulate and to reflect on self and others. This means being open to both emotional experience and thinking about this emotional experience.
5. Therapy can also provide support for parents in or at risk of developing blocked care. Therapeutic support which offers the parent a non-judgmental, intersubjective relationship with the opportunity to experience PACE from another can strengthen emotional regulation whilst providing the parent with support to reflect on current and past experience and to make sense of how they are responding to this.
6. Hughes and Baylin (2012) describe how evidence suggests that the practice of mindfulness can increase sensitive, attuned parenting. Mindful parental attention helps children to feel cared about and deeply connected with and therefore can improve the relationship between parent and child

**PACE in PARENTING**

**PLAYFULNESS:** Playfulness characterizes the frequent parent-infant reciprocal interactions when the infant is in the quiet-alert state of consciousness. Both parent and infant are clearly enjoying being with each other while being engaged in the delightful experience of getting to know each other. Both are feeling safe and relaxed. Neither feels judged nor criticized. These experiences of playfulness - combined with comfort when he is distressed - serve as the infant’s original experience of parental love. Playfulness within DDP, modeled on these early interactions, provides opportunities to convey affection when more direct expressions may be resisted. The child can experience a joyful moment with the parent. The child is also likely to respond with less anger and defensiveness when the parent is able to convey a touch of playfulness in her discipline. While such a response would not be appropriate at the time of major misbehavior, when applied to minor behaviors playfulness keeps the behavior in perspective. The behavior is not a threat to either the relationship or the worth of the child.

**ACCEPTANCE:** Unconditional acceptance is at the core of the child’s sense of safety, value, and relaxed sharing with his parent. Within acceptance the child becomes convinced that his core sense of self is worthwhile and valued by his parents. His behavior may be criticized and limited, but not his “self”. He is confident that conflict and discipline involves his behavior, not his relationship with his parents nor his self-worth. While the behavior of the child may be evaluated and limited, the thoughts, feelings, perceptions, and motives of the child never are. The child’s inner life simply “is”; it is not “right” nor “wrong”. If he is criticized for his inner life, he will begin to conceal it, and feel ashamed of that aspect of himself. Accepting the child’s intentions does not imply accepting behaviour. The parent may be very firm in limiting behavior whilst accepting the motives for the behavior. This combination of making a clear difference between unconditional acceptance of intentions and expectations regarding behaviors is probably the most effective way for a child to experience less shame toward self and more guilt toward others when he engages in inappropriate behavior. Inner-directed guilt, in the absence of pervasive shame, is probably the most effective circumstance for facilitating socially appropriate behaviors.

**CURIOSITY:** Curiosity - without judgment - is crucial if the child is to become aware of his inner life and then communicate it to his parents. Curiosity does not mean adopting an annoyed, lecturing, tone and demanding, “Why did you do that?” Curiosity involves a quiet, accepting tone that conveys a simple desire to understand the child: “What do you think was going on? What do you think that was about?” The child usually knows that his behavior was not appropriate. He often does not know why he did it or he is reluctant to tell his parent why. With curiosity the parents are conveying their intention to simply understand “why” and to assist the child in such understanding. The parents’ intentions are to assist the child, not lecture him and convince him that his inner life is “bad” or “wrong”. With curiosity, the parents convey a confidence that by understanding the underlying motives for the behavior, they will discover qualities in the child that are not shameful. As the understanding deepens, the parent and child will discover that the behavior does not reflect something “bad” within the child, but rather a thought, feeling, perception, or motive that was stressful, frightening, and/or confusing and seemingly could only be expressed in behavior. As the understanding deepens, the child becomes aware that he can communicate his inner distress to his parents. He is much less likely to engage in that behavior again, since there is no need for it. He is also more able to step back from the behavior, be less defensive about it, and experience guilt about it. For curiosity to be experienced as helpful it is not communicated with any annoyance about the behavior. Nor is it presented as a lecture. Curiosity is a “not-knowing” stance involving a genuine desire to understand and nothing more. When it leads to the child developing a deeper understanding of himself and a deeper sense that his parents understand and accept him, it will, when combined with empathy, naturally lead to a reduction in the inappropriate behavior much more effectively than will focusing on behavioral consequences.

**EMPATHY:** Empathy enables the child to feel his parent’s compassion for him just as curiosity enables the child to know that his parents understand him. With empathy the parent is journeying with the child into the distress that he is experiencing and then feeling it with him. The parent is demonstrating that she knows how difficult an experience is for her child. She is communicating that her child will not have to deal with the distress alone. She will stay with him emotionally, comfort and support him, and not abandon him when he needs her the most. The parent is also communicating her strength and commitment. The pain that the child is experiencing is not too much for her. She is also communicating her confidence that - with her sharing his distress - it will not be too much for him. Together they will get through it.

**TWO HANDS OF PARENTING**

**To Facilitate the CAPACITY FOR FUN AND LOVE**:

1. Reciprocal intersubjective experience

2. Stay physically close.

3. Integrate and resolve own issues from own attachment history.

4. Eye contact, smiles, touch, hugs, rocking, movement, food.

5. Emotional availability in times of stress

6. Safe Surprises

7. Physical contact with your child

8. Make choices for him and structure his activities.

9. Reciprocal communication of thoughts & feelings, shared activities

10. Humour and gentle teasing

11. Basic safety and security

12. Opportunities to imitate parents

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13. Spontaneous discussions of past and future

14. Routines & Rituals to develop a mutual history

**To Facilitate EFFECTIVE DISCIPLINE**

(Shame-Reduction and Skill Development):

1. Stay physically close.

2. Make choices for him and structure his activities.

3. Set & Maintain your favored emotional tone, not your child’s

4. Accept thoughts, feelings, and behaviors of child

5. Provide natural and logical consequences for behaviors

6. Be predictable in your attitude, less predictable in your consequences

7. Reattunement following experiences that create shame

8. Interrupt cycles of resistance: “mom time”

9. Match his affective expression of emotion, not the emotion (fear, anger) itself.

10. Use permission, thinking, practicing, having limits, being supervised.

11. Employ quick, appropriate, anger, not habitual anger or annoyance

12. Clarify with empathy that it is the child’s problem not your problem

13. Use the child’s anger to build a stronger connection

14. Reciprocal communication of thoughts and feelings

15. Be directive and firm, but also be attuned to the affect of your child

16. Greatly limit your child’s ability to hurt you, either physically or emotionally.

17. Integrate and resolve own issues from own attachment history.

**The following edited extract is taken, with permission.**

“A child can best be understood by focusing not so much on the behavior that you can observe, but rather on the nature of the child’s intentions that underlie the behavior. The child’s intentions include the thoughts, feelings, perceptions, and motives that are associated with the resultant behavior. Often these features of the child’s inner life are associated with previous events that were traumatic and/or shameful. Thus, the meaning of the behavior is often closely tied to the meaning of those past events in the child’s mind. To ignore the child’s inner life, we will have only the most superficial understanding of him. To encourage the development and expression of his inner life we need to first make him feel safe. If he knows that he will be judged negatively for his intentions, they will remain hidden. To provide the experience of safety, a parent might well consider PACE.”

“Hughes, D. (2006). Creating PLACE: parenting to create a sense of safety. In *Adoption Parenting: Creating a toolbox, building connections*. MacLeod, J. & Macrae, S.(Eds.). Warren, NJ: EMK Press. p. 57-61

**WORKING WITH YOUNG PEOPLE IN SHORT TERM AND RESIDENTIAL CARE**

Frequently young people with the most serious emotional and behavioral challenges secondary to a history of trauma and attachment are in short-term placements or in residential care. There are some who worry that in these placements—where the relationships are not long term—attachment relationships with specific caregivers should not be a treatment goal. Yet these young people need to form attachments with their primary caregivers if they are to make any significant progress in their psychological development. Therapeutic support to develop such relationships cannot wait until they are in a stable long-term placement or they may never be stable enough to have such a placement.

Developing good relationship skills in short term or residential care can best be done with the adults with whom the young person is living, rather than simply teaching the child skills to employ when back in the community. The relationships provided in these placements need to be based on attachment principles and strive to attain the following goals.

1. **Affect Development**: Learn to identify, regulate, and communicate affective states.
2. **Relationship Repair**: Learn to identify and resolve conflicts with those with whom we have daily contact.
3. **Accepting Comfort**: Learn to seek and accept comfort from those who are responsible for our care.
4. **Emotional Communication**: Learn to speak about one’s inner life of affect, thoughts, wishes, and intentions so that one is more deeply understood. (Deepen reflective functioning)
5. **Motives of the other**: Learn to more accurately perceive and understand the motives underlying the behavior of those with whom we have daily contact. (Deepen mentalization skills)
6. **Imitation**: Learn to value the process of learning through imitation (mentoring) the basic skills and interests of those who are responsible for our care.
7. **Self-Discovery**: Learn to discover positive qualities of self through the experience of the positive impact that one is having on those who are responsible for one’s care (primary intersubjectivity). Learn to discover the vulnerable and “unwanted” parts of self and explore without shame their meanings and reduce the negative impact of these features on self and other.

These important psychological goals are facilitated by attachment-focused relationships. In short term or residential settings such relationships are attainable if the following are in place.

1. The overall mission and the daily care provided by the program needs to be attachment-focused. This focus needs to be in place within management and among all of the adults responsible for the young person’s care.

2. The young person needs to be provided with a few key individuals who are available for the development of an attachment. These key individuals are given the training and support needed to foster the young person’s attachment with them.

3. Employment stability—with low turnover—of the key workers who provide these relationships is fully recognized and supported as a necessary program goal that is crucial for the developing attachments.

4. The young people—and their key workers—need support to be able to experience therapeutic grief and loss when the young person or the key worker leaves the programme. This support includes the opportunity to therapeutically explore the separation in advance and often to have limited contact after one has left.

5. One of the key workers is present in the therapy sessions in order to support the young person in engaging in the therapy—including the focus on the traumatic history—and also for the therapy to support the attachment between the young person and key worker.

**DDP Informed Resources**

**Books:**

Baylin, J. & Hughes, D. A. (2016) The Neurobiology of Attachment-Focused Therapy: Enhancing Connection & Trust in the Treatment of Children & Adolescents (Norton Series on Interpersonal Neurobiology). New York: W.W. Norton

Bombѐr, L. M. & Hughes, D. A. (2013) Settling to learn. Settling troubled pupils to learn: why relationships matter in school. London: Worth Publishing Ltd.

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Hughes, D. & Baylin, J. (2012)Brain-Based Parenting: The Neuroscience of Caregiving for Healthy Attachment New York: W.W. Norton

Hughes, D. A.; Golding, K.S. & Hudson, J. (2019) Healing relational trauma with attachment-focused interventions: Dyadic Developmental Psychotherapy with children and familiesNY: W.W. Norton & Co.

Hughes, D. & Gurney-Smith B. (2020) The Little Book of Attachment:  Theory to Practice in Child Mental Health with Dyadic Developmental Psychotherapy. W.W. Norton

Golding K. S. (2008) Nurturing Attachments. Supporting Children who are Fostered or Adopted. London: Jessica Kingsley Publishers.

Golding, K. S. (2014) Nurturing Attachments Training Resource. Running Groups for Adoptive Parents and Carers of Children Who Have Experienced Early Trauma and Attachment Difficulties London: Jessica Kingsley Publishers

Golding, K. S. (2014) Using stories to build bridges with traumatized children. Creative ideas for therapy, life story work, direct work and parenting. London: JKP

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Golding K. S. (2017) Everyday parenting with security and love. Using PACE to provide Foundations for Attachment. London: Jessica Kingsley Publishers.

Golding, K. S. & Hughes, D. A. (2012) Creating Loving Attachments. Parenting with PACE to nurture confidence and security in the troubled child. London: Jessica Kingsley Publishers

Golding, K. S. & Wood, A. (2021) A Tiny Spark of Hope: Healing Childhood Trauma in Adulthood. London: Jessica Kingsley Publishers

Golding, K.S.; Phillips, S. & Bombѐr, L. M. (2021) Working with relational trauma in education. A practical guide to using Dyadic Developmental Practice with Educators. London: Jessica Kingsley Publishers

Norris, V. (2019) By Your Side. Support for children moving families. Foster Carer and Adopter Guide and Practitioner Guide. Hfds: The Family Place <https://www.byyourside.online/publications>

Norris V. (2018) Not again little owl. Hfds The Family Place https://www.byyourside.online/publications

Phillips S.; Melim, D. and Hughes, D. A. (2020) Belonging: A Dyadic Developmental Practice framework for trauma-informed education. San Francisco: Rowman & Littlefield

**Chapters:**

Golding, K. S. (2019) Chapter 11. Resetting the fabric of love: real-life applications that promote emotional connection in the day-to-day experience of looked-after and adopted children and their parents. . In: J. Mitchell, J. Tucci & E. Tronick The Handbook of Therapeutic Care for Children. Evidence-informed approaches to working with traumatized children and adolescents in foster, kinship and adoptive care. London: JKP

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Wingfield, M. (2018) Adoptive parents’ experiences of Dyadic Developmental Psychotherapy. Clinical Child Psychology & Psychiatry. [https://doi.org/10.1177/1359104518807737](https://doi.org/10.1177%2F1359104518807737)

**DVD & CD**

<http://danielhughes.org/Dan/20Hughes/20Web/20Pages/booksdvd.html>

Dan Hughes and Jan Koomar SAFE PLACE: Parenting strategies for facilitation attachment and sensory integration.

Dan Hughes Building the bonds of attachment

Dan Hughes Developing attachment family therapy examples

<http://www.dyadicdevelopmentalpsychotherapy.org/bookspub.html>

Dan Hughes A Videoed Conversation: Integrating Neurobiology into DDP – 15 years on

<https://www.familyfutures.co.uk/product/dan-hughes-videoed-conversation-integrating-neurobiology-ddp-15-years/>

Michael Trout The hope filled parent <http://danielhughes.org/Dan/20Hughes/20Web/20Pages/booksdvd.html>  
  
A day with Dan Hughes, Falkirk 2009 <http://www.adoptionuk.org/s/shopcategory/100516/100534/audiovisual/>

Please refer to website (DDPnetwork.org), Resource Library for list of available relevant video clips and podcasts.

**Additional Reading List**

### Attachment Theory

**Bowlby J (1988/1998)** A secure base. Clinical applications of attachment theory. London: Routledge

**Clarke A.M. and Clarke A.D.B. (2000)** Early Experience and The Life Path. London: JKP

**Howe D. (2005)** Child Abuse and Neglect. Attachment, development and intervention. Palgrave

**Siegal D.J & Hartzell M (2003)** Parenting from the inside out. NY: Tarcher/Putnam

### Trauma

**Dana D. (2018)** The Polyvagal Theory in Therapy. Engaging the rhythm of regulation. W.W.Norton & Co.

**Mitchell, J., Tucci J. & Tronick E. (2019)** The Handbook of Therapeutic Care for Children. Evidence-informed approaches to working with traumatized children and adolescents in foster, kinship and adoptive care. London: JKP

**Porges, S. W. (2017)** The pocket guide to the polyvagal theory. The transformative power of feeling safe. NY: W.W. Norton & Co.

**Porges, S. W. & Dana, D. (2018)** Clinical Applications of The Polyvagal Theory. The emergence of Polyvagal-informed therapies. W.W. Norton & Co.

**Solomon M.F. & Siegel D.J. (2003)** Healing trauma. Attachment, mind, body and brain. London: W.W Norton & Co.

**Sieff, D. F. (2015)** Understanding and healing emotional trauma. East Sussex: Routledge

**Siegel, D. J. (2007)** The Mindful Brain. NY: W.W. Norton & Co.

### Shame

**Kaufman G (1996)** The Psychology of Shame. Theory and treatment of shame-based syndromes. NY: Springer Publ Co. 2nd ed. (1st ed: 1989).

**Tangney, J. & Dearing, R. (2002).** Shame and guilt. NY: Guilford Press.

**Education**

**Bombèr L. M. (2007)** InsideI’m hurting. Practical strategies for supporting children with attachment difficulties in schools. London: Worth Publishing Ltd.

**Bombèr L. M (2011)** What about me? Inclusive strategies to support pupils with attachment difficulties make it through the school day. London: Worth Publishing Ltd.

**Forbes, H. T. (2012)** Help for Billy. A beyond consequences approach to helping challenging children in the classroom. Boulder, Colarado: BCI

### Residential Care

**Barton, S.; Gonzalez, R. & Tomlinson, P**. (2012) Therapeutic residential care for children and young people. An attachment and trauma-informed model for practice. London: Jessica Kingsley Publishers

### Parenting and Interventions

**Booth P.B. & Jernberg, A.M. (2010)** Theraplay: Helping parents and children build better relationships through attachment-based play (3rd Ed) Jossey-Bass.

**Marvin R; Cooper G; Kent H & Powell B (2002)** The Circle of Security Project: Attachment-based intervention with caregiver-pre-school child dyads. Attachment & Human Development. 4, 1, 107-124

**Norris, V. & Rodwell, H. (2017)** Parenting with Theraplay®Understanding attachment and how to nurture a closer relationship with your child. London@ JKP

**Dozier M. (2003)** Attachment-based treatment for vulnerable children. Attachment & Human Development, 5,3, 253-257

**Elliott, A. (2013)** Why can’t my child behave? Empathic parenting strategies that work for adoptive and foster families. London: Jessica Kingsley Publishers

**Lacher D.B, Nichols T & May J.C. (2005)** Connecting with kids through stories. Using narratives to facilitate attachment in adopted children. London/Philadelphia Jessica Kingsley Publishers.

**Lloyd, S. (2016)** Improving sensory processing in traumatized children, Practical ideas to help your child’s movement, co-ordination and body awareness. London: Jessica Kingsley Publishers

**Adolescence**

**Allen J. P & Land D. (1999)** Attachment in Adolescence. In Cassidy & Shaver (eds) Handbook of Attachment, Chapter 15, Guilford Press

**Downes C (1992)** Separation revisited. Adolescents in foster family care Surrey: Ashgate Publishing

**Siegel, D. J. (2014)** Brainstorm. An inside-out guide to the emerging adolescent mind, ages 12 – 24. London: Scribe

**Staff, R. (2016)** Parenting adopted teenagers. Advice for the adolescent years. London: Jessica Kingsley Publishers

**Taylor, C. (2010)** A practical guide to caring for children and teenagers with attachment difficulties. London: JKP.

1. Toward a rational diagonosis for children with complex trauma histories. Bessel van der Kolk, MD *Psychiatric Annals 35:5 May 2005, Pp.401-408* [↑](#footnote-ref-1)
2. **See: Complex Trauma in Children And Adolescents** A. Cook, J. Spinazzola, J. Ford, C. Lanktree, M. Blaustein, M. Cloitre, R. DeRosa,

   R. Hubbard, R. Kagen, J. Liautaud, K. Mallah, E. Olafson, B. van der Kolk Psychiatric Annals, 35:5 May, 2005, 390-398. [↑](#footnote-ref-2)
3. See Trevarthen, C. (2001) Intrinsic motives for companionship in understanding: Their origin, development, and significance for infant mental health. *Infant Mental Health Journal, 22, 95-131* [↑](#footnote-ref-3)
4. Bowlby, J. (1969/1997) *Attachment and Loss, Vol. 1 Attachment.* London: Hogarth Press; New York: Basic Books.

   Bowlby, J. (1973/1998) *Attachment and Loss, Vol. II Separation, Anxiety and Anger.* New York: Basic Books.

   Bowlby, J. (1980/1998) *Attachment and Loss. Vol. III Loss: Sadness and Depression*. New York: Basic Books [↑](#footnote-ref-4)
5. As is the case elsewhere in this handout, the word parent implies any adult in a caregiving role, including foster cares, kinship carers and residential care staff [↑](#footnote-ref-5)
6. Hughes, D. & Baylin, J. (2012)*Brain-Based Parenting: The Neuroscience of Caregiving for Healthy Attachment* New York: W.W. Norton [↑](#footnote-ref-6)