Dyadic Developmental Practice: Psychotherapy and Parenting (DDP)

Level One: Introducing a Framework for Therapy and Parenting Developmentally Traumatized Children

Supplementary Material for optional use alongside DDP Level One Training Book

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Sample Programme

Day One

Introductions, Course objectives and Introduction to DDP
Introduction to Theory:
- Developmental Trauma and Interpersonal Neurobiology
- Attachment Theory
- Intersubjectivity

Shame
Introduction to PACE

Day Two

Core Components of DDP
- PACE (continued)
- Co-regulation of Affect
- Co-creation of Narrative
- Affective/Reflective (A/R) Dialogue

Practicing DDP (1) - in small groups of 3-4

Day Three

Working with Parents and Caregivers
- Aims of work, including making sense of parent's behaviour
- Exploring parent's attachment and parenting history
- Changing monologues to dialogues
- Blocked Care

Practicing DDP (2) - in small groups of 3-4

Day Four

Information about DDP, DDPI and next steps, such as certification
Framework for Dyadic Developmental Parenting
- Eg 21 "S's" (Dan Hughes), Parental activities, goals and means of achieving them. Parenting in the moment (Kim Golding)
- Making sense of why some parenting approaches don't work well

Interventions when relationships may be short term
Assessment
Research and Outcomes
Practicing DDP (3) - in small groups of 3-4

NEUROBIOLOGICAL IMPACT OF DEVELOPMENTAL TRAUMA

"...it is not pain and fear per se that constellate trauma; rather trauma is constellated when we experience pain and fear *and* there is nobody to accompany us and help us process our emotions." (p226) [1]

The interpersonal neurobiology of trauma (Eg see Dan Siegel, Allan Schore) is the study of how a person's early experience of abuse and neglect can impact on the biological structure and function of the brain and nervous system. Learning to trust and mistrust other people begins very early in life. The development of basic trust is a preverbal process that relies on the infants' use of learning based on the facial expressions, tones of voice, body language, and quality of touch in interactions with caregivers.

Polyvagal Theory (Stephen Porges) helps us to understand the neurobiology, and provides a theoretical basis for many of the elements of DDP.

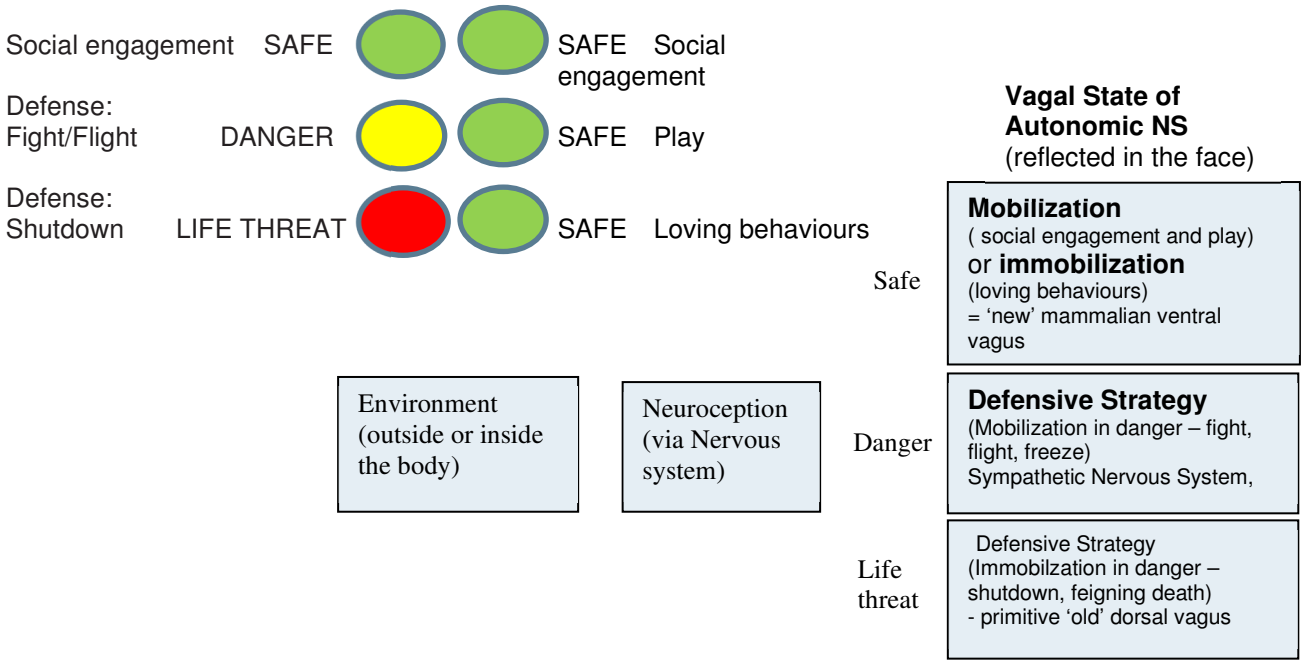
Porges (Conference presentation, Melbourne, 2014) talks about connectedness as a biological imperative. Regulation is embedded in relationships.

- Evolution provides an organising principle to understand neural regulation of the human autonomic nervous system.
- There are three neural circuits which can be used to adapt to safe, dangerous and life threatening environments. These are phylogenetically ordered such that we use the newer circuits (in evolutionary terms) first but when these don't work we will use older circuits.
- Neuroception triggers neural circuits ie detect safety, danger or life threat. (NB this is not perception as it is out of awareness).

Two vagal circuits:

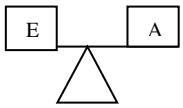
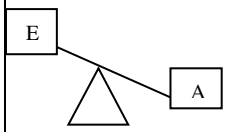
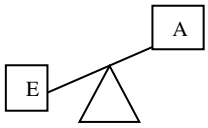
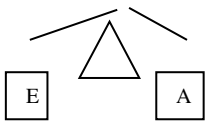
1. Social engagement = Connection. We mobilize (eg play) or immobilize (eg cuddle) in safety. Mediated by 'new' vagus. Linked to heart and lungs. = **open and engaged**
2. Connection is displaced by disconnection. We mobilize (Fight, Flight, Freeze) or immobilize (Dissociate) in danger. Mediated by 'old' vagus. Linked to gut. = **defensive**

Therefore, social engagement and defense use same circuits via new vagus or old vagus. This means can't be defensive and open and engaged at the same time. If we remain open and engaged the other person will move from defensive to open and engaged also.



[1] Chapter 11 Connecting conversations. Expanding our understanding to transform our trauma-worlds. In D. F. Sieff (2015) 'Understanding and healing emotional trauma. Conversations with pioneering clinicians and researchers' East Sussex: Routledge

MISCUING ATTACHMENT NEEDS: HIDDEN AND EXPRESSED NEEDS

Attachment Pattern	Expressed Need	Hidden Need	Head or Heart
Secure	**Exploration and Attachment** **Child** I will tell you when I need comfort and reassurance. I will enjoy you helping me to explore **Parent:** Offers comfort and reassurance when needed. Helps the child to explore and learn in the world	**None**	Can use head and heart  Attachment and exploration needs are in balance
Avoidant	**Exploration** **Child:** I will act like I want to explore even when I need comfort I will not show my need for comfort and reassurance **Parent:** Help child to explore and learn in the world, but notice when this need is miscuing the parent to hide attachment needs.	**Attachment** **Child:** I will do it by myself I fear my need of you I will push you away **Parent:** Help child to feel comfort and safety with the parent. Support child to accept nurturing. Co-regulate emotion that is hidden. Help to trust emotion and to know that it will be acceptable to others.	Uses head, ignores heart  Exploration needs appear high, attachment needs appear low.
Ambivalent	**Attachment** **Child:** I can't trust in your availability. I need you to attend to me all the time. **Parent:** Demonstrate availability to the child, but notice when this need is miscuing the parent to hide exploration needs. Provide predictability and consistency Provide structure and routine Co-regulate expressed emotion.	**Exploration** **Child:** I will not show my need to separate and explore. I will pull you in and push you away to keep you noticing me. **Parent:** The child needs to learn to be apart and to feel secure in parent's reliability. Support to trust in parent's reliability, to trust knowledge, and not just to rely on their feelings.	Uses heart, ignores head  Exploration needs appear low, attachment needs appear high
Disorganized-controlling	**To be in control** **Child** I will not need you I must be in control **Parent** Help child to trust in your ability to meet their need, Help child to trust in your abillty to keep them safe	**Attachment and exploration** **Child** I can't explore the world I can't seek comfort I am too busy keeping myself safe **Parent:** Help child to feel safe. Provide a low stress environment. Help child to trust feeling and thinking Help child to develop emotional regulation and reflective function abilities.	Can't use head or heart  Need to control overrides attachment and exploration

Steps in Affective Reflective Dialogue

By Dafna Lender

Example: a child, Johnny, who could not accept caregiver's help when he was cold. Johnny didn't have gloves on (-10 below!) and when dad offered Johnny his gloves, Johnny wouldn't take them.

1. **Be with the child in the moment and accept**…must do this first. Bring out the experience in this: "Oh wow, you were cold and you were alone and maybe your hands even hurt!"
2. **Empathize**: "Oh that must have been hard/uncomfortable/yucky/not nice". Use these more general words to describe their state rather than categorical affect words (sad, mad, angry) because when you are first developing the narrative, labeling emotions can make a child feel overwhelmed and they will retreat.
3. **Be curious - wonder why**: This step should stay in a story-telling, somewhat sing-song voice-"Why would a boy be outside in the cold and have such cold hands but not be able to accept dad's help?" (Caution: Parent may want to jump in here and say something like: "I would have helped him!" Don't allow this at this point. Put your hand on the parent's arm, or give an understanding, acknowledging look, and then say "Oh dad, I know you would have, but right now we're trying to figure out what it was like for Johnny at that moment, so let's wait to do the problem solving for later."
4. **Continue to develop the narrative**: Best not to look directly at the child at this stage. Continue to wonder to yourself about the situation (say "Hmmmm, I wonder why? Why would a boy have cold hands and not take the gloves?" Then look at the child and ask, "Do you know why?" And child will often say "No" or shake their head.
5. **Getting permission**: Ok, thanks for telling me. That's ok not to know. (**Acceptance**) Therapist can then ask "Can I guess? Would that be ok? The child probably won't verbally respond but they will nod, shrug or have an inquisitive look in their eye. "Ok, good, I will guess" Now the therapist must come up with some ideas!
6. **Guessing:** Ask in a rhetorical voice so child doesn't feel obliged to take a position. Say "Could it be that the reason you couldn't use your dad's help was because you felt like you just couldn't move or say anything at all?" Or "Could it be that you were worried that you were in trouble and taking the gloves would mean you would get in more trouble?" until child responds affirmatively (often times it will be a nod of the head, not an actual word). Or, if they were previously staring into space and suddenly they make eye contact, that also usually means you've hit the mark. Even if you don't get it exactly right typically the child will say yes if you are in the "ballpark of the affective state" the child would have been experiencing.

7. **Respond**: "Oh, ok! Thanks for telling me that!" this then starts aspects of the cycle above over again… "Oh my gosh! You couldn't use the help because you were afraid you were in trouble! Maybe you thought taking dad's gloves would make you get into worse trouble! No wonder you had a hard time accepting the gloves!" (**empathy**)
8. **Further development of the narrative**: That makes sense! Just helping the child arrive at this and telling them what they are doing makes sense can be SO VALIDATING because the messages they are getting everywhere else are things like: you are bad, you are wrong, you can't follow rules, you need to use your words etc…If all you do is validate and begin to help child make sense of this narrative that is huge progress. This would be success.
9. Ask the child if he could tell his dad how he felt. If he can't/doesn't want to, offer to talk for the child. Tell him that if you say anything wrong, he can let you know by telling you but also you will look at him and notice. If you get agreement for this, then move closer to child's side so you can talk for him from his perspective. Say something like "Dad, my hands were so cold but when you came over and saw my hands, I thought I did something wrong! I thought you would be mad at me for not taking my gloves and for not asking for help. So, I couldn't take them, dad!"
10. If parent is at the stage of being able to do it, having the **parent empathize** would add even more depth to the work. If you've gotten agreement from the parent ahead of time, you could coach the parent by suggesting what to say. Like "Dad, did you hear what your son just said? He said he was scared he was in trouble for having cold hands!" "Dad, can you tell your son what you think that must have been like for him?"
11. Dad says "Thanks for telling me son. That must have been scary if your hands were so cold and I was offering help, but you were scared, you were in trouble. No wonder you couldn't answer me or do what I told you to do." This part of the session can keep developing where the therapist talks for the child and expresses more themes.
12. The final part is the **Reflective** part of the A/R dialogue: zooming out and making meaning by talking in a melodic voice about the whole discussion in summary. Highlight what they learned about each other and what you learned about them. Recognize that they were brave and that they worked hard to deal with the stressful issues. Highlight any aspects of the parent-child relationship that are positive.
13. Problem-solve about similar events in the future. Ask the child and parent for some suggestions.

EXPLORING PARENTING THROUGH THE LENS OF ATTACHMENT HISTORY[2]

Understanding their own experience of being parented and how this has impacted on them as parents to their children can help the parent to understand why they are getting into patterns of relating to their children.

> For example: If a person experienced their mother walking out of the family home when they were 5 they may have been left with a feeling of not being quite good enough. If their child behaves in a rejecting manner to them this might trigger these feelings, affecting how they react to the child. Alternatively, if a person experienced a mother as cold and distant, they might equally struggle with meeting the emotional needs of their own child.

The following questions are designed to help parents reflect on their early experience and the impact it has had on their parenting. It can be helpful to write some answers down so that they can reflect upon this again in the future. This can be difficult to do. It may re-awaken some sad or painful memories or it may highlight experiences that they didn't have as a child.

1. **What words would you use to describe yourself as a parent?**

   For each of these words reflect on them in relation to your own parents. Do they also describe the way you were parented or do they describe how you have tried to be a different parent?

2. **How did your parents respond to you when you were happy or excited?**

   Can you think of a specific example? Is this similar or dissimilar to how you respond to your children when they are happy or excited?

3. **How did your parents respond to you when you were worried or anxious?**

   Can you think of a specific example? Is this similar or dissimilar to how you respond to your children when they are worried or anxious?

4. **How did your parents support you through a loss or significant separation?**

   Can you think of a specific example? Is this similar or dissimilar to how you respond to your children when they are coping with a loss or significant separation?

5. **Reflect upon a time when you were upset or distressed as a child.**

   How did you calm or comfort yourself? How did your parents help or not help with this? How do you calm and comfort your children when upset or distressed? Is this similar or dissimilar to your own experience?

6. **Reflect on how you were disciplined and given boundaries as a child?**

   Are there ways in which this is similar or dissimilar to the way you discipline and provide boundaries for your children?

7. **Can you think of any times when you felt hurt by your parents or by someone else?**

   How did you respond to this hurt? How did your parents' respond to your hurt? Do your children respond similarly or dissimilarly if they feel hurt by someone? Do you think this experience has impacted on how you support your children when they feel hurt by someone?

8. **In reflecting upon these questions have you noticed things that you find especially difficult to remember about your childhood?**

   How do you think that this lack of remembered experience has impacted upon you as a parent?

9. **What weaknesses do you think you have brought to parenting that have come from your experience of being parented?**

10. **What strengths do you think you have brought to parenting that have come from your experience of being parented?**

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[2] Adapted from: Golding, K. S. (2014) Nurturing Attachment Training Resource. London: Jessica Kingsley Publishers

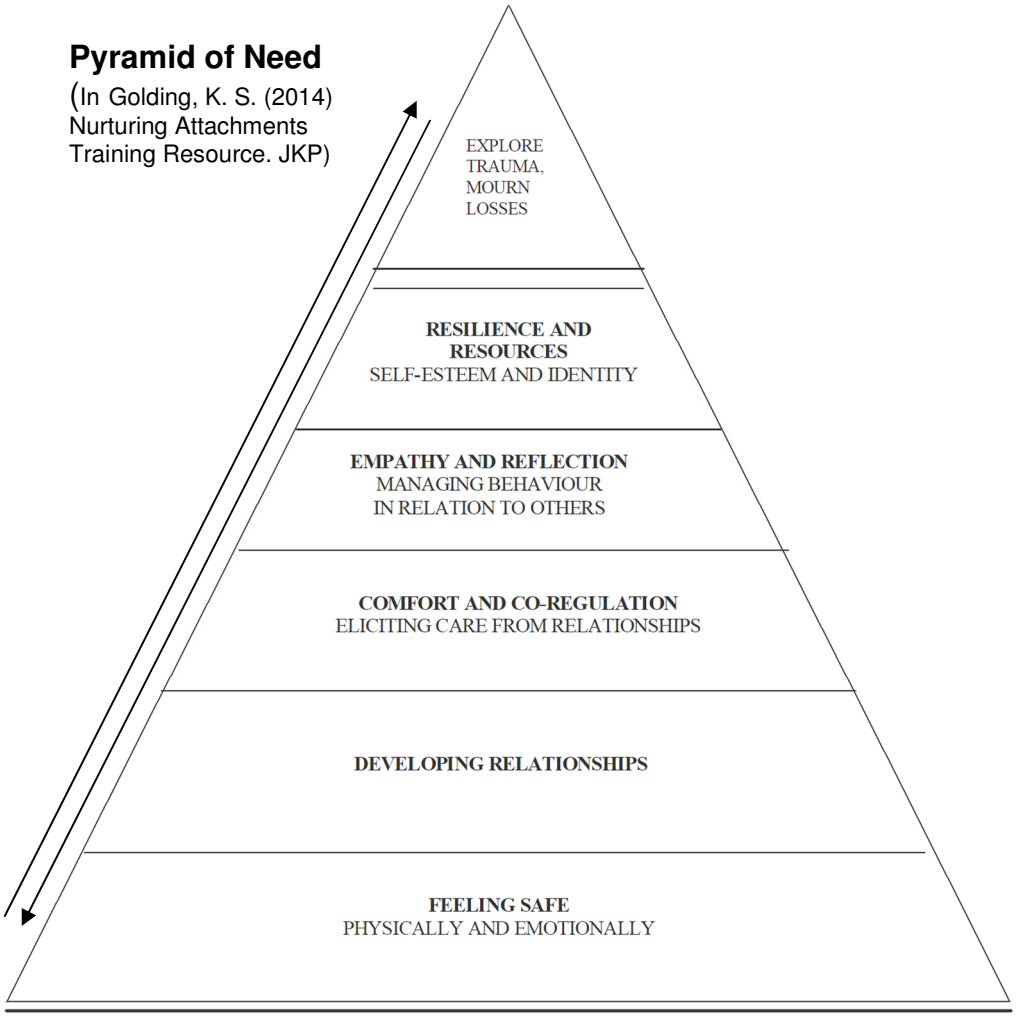
LOSS OF TRUST IN INFANCY
DEVELOPMENT OF BLOCKED TRUST

Good Enough Parenting	
Connection	**'Correction' (developing prosocial behaviours)**
First Year of Life Attuned parenting matched to emotional needs of young child. Provide experience of intersubjective relationship Offer attachment security by offering comfort and facilitating exploration as needed	**Second Year of Life** Child begins to develop autonomy and to assert independence Structure and supervision become important Parent also becomes rule maker and limit setter as boundaries are put in place: 'agent of socialization'
Development of **Trust** Experience of unconditional relationship – child is loved 'no matter what'.	Trust allows child to believe in parents' good intentions and to know that the relationship remains unconditional. Accepts limits on behaviour because knows loved no matter what

Frightening Parenting	**Different Parenting**
No Connection	**Connection Plus Correction**
First Year of Life Poor and frightening parenting experience Poor experience of attunement and intersubjectivity Insecure/frightening attachment experience Loss and separation Multiple caregivers	**Through Childhood** Child is provided with improved parenting via fostering, adoption, kinship care These parents have missed the sequential opportunity to build trust and then set boundaries Parent tries to offer an unconditional relationship whilst also setting limits on the behaviour.
Development of **Mistrust** Relationship is conditional – child is loved 'only if' Development of mistrust sensitizes the nervous system Social monitoring system is alert for signs of rejection, anger, neglect. Social engagement system becomes inactive Social defence system becomes active	Parent provides parenting that builds trust and provides socialization at the same time rather than sequentially. This strengthens mistrust, as the ability to trust becomes blocked Without trust ordinary parenting feels like abandonment and pain. 'You do not love me. I am not good enough. You will hurt me and leave.' **Blocked Trust:** Child learns to resist authority and to oppose parental influence. Do not trust in parents' good intentions or in unconditional support and love. They trust in themselves rather than others and thus are controlling in their behaviours. Control means they are not open to reciprocity. They influence without being open to influence and this feels safer.

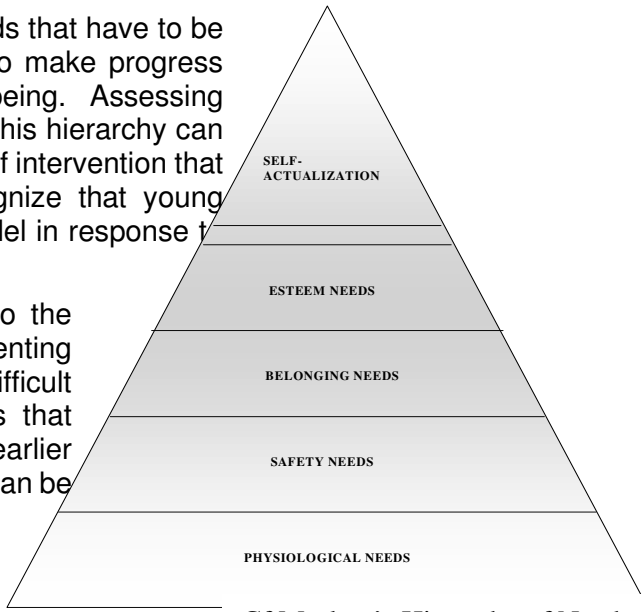
THERAPEUTIC PARENTING

Pyramid of Need
(In Golding, K. S. (2014) Nurturing Attachments Training Resource. JKP)



This model suggests a hierarchy of needs that have to be met if children and young people are to make progress towards emotional health and well-being. Assessing where a young person currently lies on this hierarchy can be helpful in guiding the type and focus of intervention that might be offered. This needs to recognize that young people can move up and down this model in response t current circumstances.

This can also help focus attention onto the parenting needs of the child. When parenting aims to help children recover from difficult early experience and develop in ways that have been compromised by the earlier experience of parenting then the parent can be said to be parenting therapeutically.



Cf Maslow's Hierarchy of Needs

Therapy with Henry

We began therapy with Henry. The initial focus was on building a relationship. Activities were used which also helped him to feel more secure with his foster mother. This allowed us to explore together some of the ways he used to keep himself safe. What he came to call his 'major defences'. We explored the worry and fear underneath his anger and how hard it was to notice these feelings. Initially this exploration was very cognitive, but gradually Henry allowed himself to feel as well as to think. This will be illustrated with an example adapted from a session I had with an 11-year-old foster boy, similar to Henry.

Connect and Chat: Therapist begins with 'connect and chat' (establish storytelling and rhythm). This helps to establish the intersubjective connection within a safe relationship. It sets a tone and rhythm for the whole session.

Therapist: 'So I see you got those new trainers you wanted.'

Henry: 'Yer, Mum and I went shopping on Saturday. They didn't have the one's I wanted.'

Therapist: 'That must have been pretty disappointing. You have been so looking forward to getting them.'

Henry: 'No I like these. They have a light in the heel and everything.'

Therapist: 'How lovely, to get a day out shopping with Mum, and to get the trainers you have been waiting for. Even though they weren't exactly the right ones, the light makes them pretty cool, right?'

Henry: 'Yer, and I nearly didn't get them. Not after Friday night.'

PACE: The therapist maintains and models "The Attitude". **P**layful connections. **A**ccepting of the child's inner world. **C**urious about the meaning underneath the behaviour or other communication. **E**mpathy for the child's emotional state.

Therapist: 'Oh, things were not so good on Friday, eh?'

Henry: 'Yes, Chelsea was being a pain. I was so mad with her.'

Therapist: 'That sounds hard. Was she being annoying?'

Henry: 'Yes, or maybe. I don't know. I just got so angry with her.'

Therapist: 'That sounds kind of confusing.'

Henry *(with tears in eyes)*: 'She was just being herself really. I shouldn't have got so angry.'

Therapist: 'Oh Henry, it sounds like Friday night was tough. You got angry, and now you are feeling so bad about getting angry. I guess it's making you feel sad as well.'

Henry: 'Not really sad, just cross with myself.'

Therapist *(playfully):* 'That sneaky sadness, showing itself when you don't want it to. *(Henry smiles* sheepishly). It sounds like you are giving yourself a hard time over this. Do you want to tell me a little more about what happened?'

Notice Themes: Respond to themes as presented by child with same storytelling, interested and curious tone. This maintains the intersubjective relationship allowing the child to continue to feel safe as the focus moves onto something more tricky to think about.

Henry: 'I pretty much lost it with Chelsea. She was being so ridiculous, lying down on my bedroom floor. We were trying to watch a DVD, but she was so irritating. I just got angry.'

Therapist: 'That sounds difficult. You were trying to watch the DVD together. Was she not letting you watch it?'

Henry: 'Well, she was, but she just wouldn't sit properly. I didn't want her lying on the floor. I got mad with her and Mum came up and sorted it out.'

Therapist: 'That's why you were worried about the shopping trip? You thought, maybe, that Mum would cancel because you got so angry with Chelsea.'

Henry: 'Yer, but she didn't. We went anyway.'

Therapist: 'I wonder why you got so angry. I know Chelsea is often irritating, but it is unusal for you to get so mad with her isn't it?'

Henry: 'I don't know. She just wouldn't do what I told her. She was a right pain.'

Follow-Lead-Follow: The practitioner explores the stories the adult or child has to tell. These narratives are co-created, emerging out of joint storytelling. The practitioner as conductor in the telling must both follow and lead in turn. The practitioner is non-directive (follow) allowing the other to lead them into themes important to him. The practitioner is directive (lead) to deepen exploration of the theme. Thus the practitioner remains attuned to the other, as they both explore = Follow-Lead-Follow. In this way the practitioner finds a balance between being non-directive and directive, following the themes that emerge and leading the other to a deeper understanding, whilst helping him to be safe feeling it. The practitioner sets a rhythm to the telling which allows the story to emerge.

Therapist: 'She can be very frustrating can't she?'

Henry: 'Yer, for me anyway. She just will not do as she's told.'

Therapist: 'So, what were you actually angry about?'

Henry: 'Her not doing what she was told. I wanted to keep her quiet because of the visitors downstairs and she just would not do it.

Therapist: 'So you had some responsibility to keep Chelsea quiet so they could have a good time. Were you feeling a sense of: 'I've got to sort this'?'

Henry: 'Yes, just shut up, do as you are told.'

Therapist: 'Because this is important?' And you were helping the adults out by trying to keep Chelsea amused.'

Henry *(looking sad):* 'And she just wouldn't do as she was told.'

Therapist (empathising): and she wouldn't do as she was told.

Co-Regulation of Affect: The practitioner helps the other to manage moments of emotional dysregulation and defensiveness through an open and engaged stance. Clients are helped if their affective response to events is co-regulated by the practitioner's affective response. The practitioner matches the vitality and intensity of the affect whilst staying regulated themselves. They respond with empathy, verbally and

nonverbally. This helps the other to become regulated and able to be open and engaged again. Now practitioner and clients can engage in reflection again.

Co-Create Meaning of Experience: The therapist helps to make meaning from experience; Young people are likely to struggle to make sense of both present and past experience. Their reflective capacities can be weak, and they are often driven by their emotional experience. When their attention is held by the adults' attentive stance the adults have an opportunity to put words to experience. The young people gradually identify and more fully express their inner life; They integrate the meaning given to the experience through the interwoven perspectives of self and other. As young people develop their reflective capacity they become more able to reflect on their experience, giving them more flexibility in responding.

Affective-Reflective Dialogue: The therapist helps the child to engage in an affective-reflective dialogue allowing exploration of current and past experience. This brings the heart into connection with the mind, creating a rich story within which the inner lives of the young person can be explored, deepened, elaborated and made more coherent. The young person feels safe in the emotional co-regulation allowing his experience to emerge in a rich story which can touch and change the experience of those witnessing it. The story-telling which emerges from the A-R dialogue provides a deepening of connection which is both safe and healing.

Therapist 'So it sounds to me like you were trying to look after Chelsea?'

Henry: 'Yer, I would have thought so, in a sense, but in the end she did get upset.'

Therapist: 'And you got upset. You were feeling so angry'

Henry: 'Yep'

Therapist: 'That sounds so tricky. Are there other times when you have tried to protect Chelsea and it hasn't worked?'

Henry: *(long pause and looking thoughtful)* 'No, I don't think so. No. Can you? *(to Foster Carer).*'

FC: 'You do feel responsible for Chelsea I think.'

Henry: 'Well yer, probably.'

FC: 'That you need to keep an eye on her and make sure she's okay.'

Therapist: 'Where does that come from do you think? Where does the need to look after Chelsea come from?'

Henry *(with sadness):* 'I think, um, from when I was at home. When I was with my mum.'

Attending to Verbal and Non-Verbal: Every communication is non-verbal, some are also verbal. The therapist attends to both verbal and non-verbal communication. Notice discrepancies between verbal and non-verbal. Helps the adult understand the experience of the other and thus be more able to co-regulate that experience and reflect upon it. When verbal and non-verbal match the communication will be deeper and more open.

Rupture and Repair: Sometimes the child will withdraw from the relationship because of something the therapist says or does, or because of some difficult experience that the child is having. This weakens the intersubjective connection between them. The

therapist takes responsibility to attend to the relationship, repairing any ruptures and letting the child know that the relationship is important. This restores the intersubjective connection.

Therapist: 'Ah, yes. You did a lot of looking after Chelsea at home didn't you. You were so little, such a lot of responsibility.'

Henry: *(Turning away from me to hide some tears)* It was fine. Mum was okay and I liked helping Mum with Chelsea.

Therapist: Henry, I am sorry if you felt I was being harsh about your Mum. That wasn't my intention at all. I was just noticing how sad thinking about this makes you feel. That's hard for you, feeling sad isn't it.

Henry: *(turning back towards me)* Yer, I hate crying. Anyway I didn't look after Chelsea too well on Friday did I?

Therapist: I can see how much that is hurting you. I am wondering if some of the hurt goes back a long way, to when you were at home and looking after Chelsea?

Henry: Maybe

Storytelling: The therapist focuses on experience being mindful of themes of attachment, abuse and neglect.

- Miscuing of attachment needs.
- Fear of reciprocal connection and need for control.
- Fear of abandonment, rejection, isolation, abuse.
- Sense of being worthless and bad.
- Despair over being unwanted, unloved.
- Shame/rage associated with the above emotional experiences.

As this story is discovered the therapist tells it to the child.

Therapist: 'I think you are feeling sad now, because I think we are getting quite deep about the pressure that has been on you to look after Chelsea. The pressure from living with mum and dad and perhaps having to do more looking after Chelsea than you should have done when you were little. I wonder, this is what I am thinking, about an 11-year-old boy who is trying to look after his sister, to help his mum because he knows it is important. Trying to make a situation good, and Chelsea wasn't letting you do it. So you were feeling a sense of: 'Oh no, its not working'. And I wondered if that triggered for you a deeper memory of when you were little and you were having to look after Chelsea and that's why you got so upset.'

Involve the parent: Parent is present and actively involved. Therapist and parent continually communicate emotionally with the child. Help child to be more aware of inner life of thought, affect, wishes and intentions as well as traumatic memories.

FC: 'Do you remember telling me how mum used to send Chelsea outside when you were out with your friend, Daniel was it?'

Henry: 'Yes, I had to look after her.'

FC: 'That was a really big ask wasn't it?'

Henry: 'Yes, and she went into the road and over to the corner shop and I wasn't there to look after her, as I was playing with my mate. Mum came out and asked me to look

after Chelsea, but me and Daniel were so busy playing that we completely forgot that Chelsea was there. So she went on to the road. Mum asked, after we had played and come in, where Chelsea was and I said I didn't know. I didn't see her go anywhere.'

The Story: In this way the story is co-created between the child, parent(s) and therapist. The therapist helps the story to develop, allowing the child to feel this affectively as well as to think about it cognitively. The parent responds to the story with acceptance and empathy. The child experiences safety moving into affect generated by recalling the experience, whilst being supported and comforted by the parent.

Therapist: 'Do you know what I am thinking? You must have been one scared boy when you realised that you had forgotten to keep an eye on Chelsea. I'm thinking you were so scared that you keep a really close eye on her now. You've forgotten that you don't have to do that all the time now, and you are still doing it. Because what might have happened? Chelsea might have been hurt, she might have died. What if a car had come along when she was on the road, and you would have thought that it was all your fault because your mum had asked you to do something that she shouldn't have expected a little boy to do. No wonder you felt angry and sad when Chelsea wouldn't do what you wanted to do, because it mattered. You were trying to keep Chelsea safe, and you've been trying to keep Chelsea safe for 7 years. Seven years you've been trying to look after Chelsea, trying to protect her in a way that a big brother shouldn't have to look after his sister. No wonder you get angry and sad when she wouldn't do what she was told. *(to FC)* He is such a brave boy isn't he?'

FC: 'I know he is, a pretty special big brother.'

Child connects with parent: Ask the child to talk to the parent; so that he can experience the parent's acceptance and empathy. If this is too hard, the therapist can give the child some words to say to the parent or talk for him.

- This increases safety, trust and attachment security.

Therapist: 'Such a special brother, but so hard for you, to keep her safe. So much responsibility for a little boy. So hard it makes you feel so sad. I just want you to turn to Jane and tell her how sad you feel.'

Henry: 'On no, not one of these. *(looks at Jane and says quickly)* 'I'm feeling sad at the moment, but I'll get over it.'

FC: 'I know you are and you don't have to get over it.

Therapist: *(talking for Henry*) But I do, Mum. I hate feeling sad. I think you won't like me if I am sad. I want to look after Chelsea. I want you to be proud of me.'

FC: That makes me feel sad. I see how hard it is for you to know I am proud whatever you are feeling. *(Henry and FC hug)* And you know that brown eyed beauty that really annoys you sometimes. I'm the one that deals with her, right. She's your sister to love and to keep a beady eye on, but it's my job to deal with her.'

Caring for the Caregivers

Children who find it hard to trust and have a strong need to move away from affect will have many defences that help them to keep us at arm's length. These are easy to see, even if not easy to move on from. Caregivers too can have strong defences in place. It is very easy to join them behind these defences because it feels like we are achieving something.

Example of Defences

- Let's think about how services have let me down. The carer becomes preoccupied, and often angry, about the services they have and are receiving. This might be focused on social work, school or therapeutic services. We might feel frustrated too and have sympathy for the carer. We might feel a need to defend our colleagues. Either way we become distracted into a focus onto services rather than the carers' experiences.
- Let's talk about the child. If we try and wonder about the carers' experiences they skilfully, and often unconsciously, move us back to thinking about the child. We already have some understanding about the child, and what might help him, so we are keen to communicate this, and we are easily pulled into this focus.
- Let's solve the problems. We both become preoccupied with finding answers to immediate problems that the child is presenting.
- Help me to feel better. The carer expresses some fears about failing, about not being good enough, but then backs away from thinking about this experience. We move into offering reassurance instead of acceptance and curiosity as we back away from the exploration also.

DDP-informed parenting support

What is different from other parenting support interventions?

- Less focus on immediate problem solving and advice giving and more focus on CURIOUS EXPLORATION
- Understand parents' EXPERIENCE of parenting the child.
- This includes understanding the IMPACT the child has on the parent.
- Understand this in the context of previous attachment history and relationship experience.
- Discover the stories together.

This involves the practitioner using PACE to:

- CONNECT with the parents and explore how things currently are.
- Help parents to consider the IMPACT on them of the experience they are having with the child.
- Elicit any EXPERIENCE of shame, anger, fear, despair, with this affective experience being co-regulated by therapist.
- Explore current experience parenting this child in the context of PAST relationship experience.
- CO-CREATE new meanings of own behaviour.

Use all this understanding to INFORM parenting of the child.

- Support parent to understand the EXPERIENCE of the child and CONNECT emotionally
- Help parent to provide CO-REGULATION and CO-CREATE new meanings of child's behaviour.
- Think with parent about how to SUPPORT behaviour of the child

Caring for the Caregivers - Example

Sue is a foster carer meeting with her fostering social worker (SW) for a support session. This dialogue provides some examples about how a conversation between them might go. The whole session is more likely to be around 1½ hours, therefore this just provides a glimpse of the process. These conversations are also repeated over many sessions as the carer comes to understand herself more fully.

Sue is caring for two boys who were placed at 5 and 6 years of age and are now 9 and 10 years. She is supported by her husband, Dave, but considers herself as the main carer. The older boy, James, is causing them most challenge with his generally oppositional behaviour, lying and stealing and resistance to their nurture. This session focuses on him.

1. Explore current experience

The foster carer needs time to offload, and to feel heard. She needs to express emotionally what she has been experiencing before she will be able to engage in any reflection with the social worker. If the foster carer is having a particularly hard time this can take a substantial amount of the session. It is important that she experiences the social worker as getting it; that she feels understood.

SW: Hi Sue, you are looking tired. Tough week?

Sue: Oh, you know, same old, same old. James is up to his usual tricks.

SW: It's a bit unrelenting, isn't it? How are you feeling this week?

Sue: Well, it's just he never changes, whatever we do. He stole again this week. I was stupid, I left my purse out. The twenty quid went of course. Will I never learn?

2. Explore the impact on the foster carer of this experience

At some point the social worker will want to move into reflecting on the experience of the foster carer. Exploring together how these difficulties are impacting upon her. This inevitably touches upon feelings of pain and a sense of failure and therefore moving to this can trigger a defensive response. In this example the defense of 'lets talk about the child' is apparent. I have imagined that the two of them have a longstanding relationship, making it easier for the social worker to gently challenge the defence. Building of safety and relationship is an important precursor to this type of exploration.

SW: That sounds frustrating. It's tough when you can't put your purse down without thinking about it.

Sue: I think something is going on at school. He won't talk about it of course, but I have a feeling he's struggling with his friends again. Not surprising, he is so bossy with them. They will only take so much.

SW: And then he won't talk to you either. I guess that is hurtful?

Sue: Well, we've tried rewards, he seemed happy to earn points but as soon as he got the reward it was back to usual. Punishments don't work either. We took his iPad away. He didn't seem to care. Nothing seems to work. I just feel out of ideas.

SW: So, he is still lying and stealing. Friendships are tricky and whatever you do doesn't seem to make a difference. On top of that he doesn't want to talk to you. It must be hard to feel you are making any difference?

Sue: Yes, as I said, same old. There are glimpses of a lovely boy underneath all this, but honestly it's hard to see this most of the time.

SW: Sue, I want to slow you down a bit. You know what I'm like! (Sue laughs). I have noticed that whenever I ask about how you are feeling you talk about James again. Is it hard to think about you in this?

Sue (laughing): I'm doing it again aren't I? I know you will stop me though. It's just so hard to think about. Painful as well I guess. Go on, do your worst.

SW: James is tough; he is resisting all the good parenting you have to offer. It's hard to have good moments with him. I am guessing that has to hurt?

Sue: He is a lovely lad, I can see that. And he has had a tough time …….

SW (Touching Sue on the arm): but it has to hurt. Let's think about you now.

Sue (thoughtfully): Well, yes. It does hurt. (tears come to her eyes). It's so hard!

SW: I can see your tears. So hard. What do you think is the hardest thing about parenting James?

Sue (brushing tears away): I don't know. I just see what he could be I guess.

SW: And you aren't able to help him be this child, are you? How does that feel?

Sue (more animated): Pretty useless. He just doesn't respond to anything.

SW (also animated): yes, he makes it so hard for you (quietening) and I am thinking it must feel like such a failure for you?

Sue (tears come again): Yes that's it. I just feel like I am letting him down. I am failing him because nothing ever changes. I dread to think where he will end up – prison like his Dad I guess.

SW: Such a big fear, and I'm guessing you would think it was your fault?

Sue: Well, yes. I said I would take him on. I should be able to make it different for him. What's the point of him coming into care if we can't make a difference?

3. Revisiting past relationship experience

As we explore with the carer her fears, frustrations and feelings of hopelessness we are also touching on the 'hot spots' for her. The points of greatest vulnerability. As we explore these it is helpful to know when she has felt like this before. Often this takes us to her attachment history.

SW: That sounds like a big worry. What is it all for if you can't make a difference? I would like to stay with those feelings of failing for a bit longer, if it is okay with you. (Sue nods). I am wondering, perhaps guessing, that James isn't the first person who has made you feel like a failure?

Sue (Thinking hard): Well I have been lucky. Dave is great, we have a great relationship. My own kids have done well. I have lots to feel good about.

SW: What about before you married, anyone then. (tears spring to Sue's eyes). I'm guessing you have felt like this before?

Sue: I had an aunt. We were very close, but she died. I was about 10. She lived a couple of streets away. I visited her every day on my way home from school. As she got sicker I would cook her stuff, try and get her to eat. Then one day my

Mum met me from school and told me she was in hospital. I never saw her again. They wouldn't let me visit.

SW: Oh, Sue, how sad. So, you never got to say goodbye?

Sue: She was only 18. Everyone said how clever she was, all the great things she should have done in life. For the longest of times I thought it was my fault. If only I could have got her to eat, maybe she would have got better. Last year, not long before my Mum died, she told me what was wrong with her – cancer. I hadn't known.

SW: So for all those years you had thought you hadn't looked after her well enough. What a big burden to have carried for all that time.

Sue: I didn't think about it as I got older. I got on with my life. Met Dave, had the kids, but yes, I guess somewhere it was still there, nagging away.

4. Co-create new meanings about foster carer's experience

Together the social worker and foster carer can now start to make sense of the foster carer's experience in the present. Her current experience with the child takes on a new meaning in the light of the exploration of past experience.

SW: As I am listening to you I am thinking about your feelings about James. They are making a lot of sense to me now. Those big fears about failing him. I am guessing they are even bigger for you because of what happened with your Aunt. I wonder if somewhere deep inside you have a sense that you have to get things right with James, because it feels like you didn't with your aunt?

Sue: Well, I don't worry that James might die, but when you say it like that it makes some sense. I haven't really thought about my aunt for years, but she has always been there in the background. I do worry about James' future, and maybe it is more important because my aunt lost her future. It kind of makes sense, but I'm still not getting anywhere with James. I'm not sure how this will help with that.

SW: I wonder if it is extra hard for you when James doesn't respond. If that is taking you back to the past then it's going to be harder for you to deal with it. It will be hard to wonder what is going on for James when you are becoming preoccupied with what a failure you feel. You may not have understood what was being triggered for you, but the feelings will be very real.

5. Connect emotionally to the experience of the child

It is important to spend sufficient time with the foster carer's own experience, and to revisit this in future sessions. This is explored affectively and reflectively, allowing the foster carer to understand and integrate her past experience so that it has less impact upon the present.

It is then important to spend time focusing upon the child. This exploration starts with reflection on the child's experience, before moving on to the how of managing the behaviour.

The focus is on making sense of behaviour and how it has been triggered by the child's underlying experience. This often involves reflection on the past, as well as current, experience. This exploration increases understanding and empathy towards the child from the foster carer.

Sue: It's strange, I feel a bit lighter somehow, like maybe there is some hope. How odd, we have hardly even talked about James, and nothing has changed there. I have been so desperate to stop all his behaviours, maybe I have lost sight of something.

SW: Any sense of what?

Sue: Well, why does he need to steal for a start, and what makes it so hard for him to talk to me?

SW: Those are great questions. I can see you are really trying to understand James now. What does he do with the money that he steals? – That seems a good place to start. I know he buys lots of sweets doesn't he?

Sue: Yes, and then tries to buy his friends with it. Of course, it links to how he's feeling doesn't it? He doesn't believe people will like him for who he is. Maybe that's why he doesn't want to talk to me as well.

SW: I wonder how you could let James know that you get this. Like, when he has stolen, or fallen out with friends. Do you think you could help him to know you understand how bad he is feeling?

Sue: Yes, I could. I just focus on what he's done wrong, or what he could do differently. I don't think I have ever told him I understand how hard all this is for him. I can certainly do this.

SW: You might need to be a bit patient. I think this will feel a bit strange to him. Give him time, and if you feel a bit despairing let me know, we can think about it together.

Sue: Yes, you are right, I can imagine me being impatient to see change, but I understand that better now. What should I do when he steals though? I can't just let him get away with it.

6. Explore behaviour support

With this exploration it becomes natural to move on to thinking about behaviour support within the context of what has been explored. The foster carers still need to manage the day-to-day impact of the child's behaviour in a way that supports the child to learn how to behave prosocially, and how to repair relationships when things do go wrong.

The social worker helps the carer to think about how to manage the behaviour in a way that maintains the connection with the child. This often moves the carer from a coercive management of the behaviour to a more collaborative support of behaviour.

The connection with the child has increased understanding and empathy for the child. This impacts on the thinking about what happened and what the child can now do to make things right again (a focus on collaborative consequences, child and carer figuring it out together, rather than on carer-imposed consequences). The carer will also become more alert to times when consequences aren't needed, instead the child will benefit from more regulatory support or closer supervision from them.

SW: No, of course not, but you might be surprised how James feels when he starts to tolerate your acceptance. You might find he is feeling pretty bad about it.

Sue: And then I punish him, just making him feel worse. But I have tried rewards as well. Wouldn't that make him feel better?

SW: Rewards can be tricky. It can lead to more pressure, to get things right. Then when he messes up he will just feel like he is letting you down, more evidence that he is the bad kid he fears.

Sue: Well if I can't punish and I can't reward what is there left?

SW: I do think that he will be helped with consequences, but they need to help him to feel better about himself. Consequences that help him repair the relationships. In fact, if you can think about this with him once he is feeling understood he will probably have all sorts of ideas about what he can do. You can figure it out together.

Sue: That feels good, and it feels more focused on him. I see now that I have just been trying to get him to stop stealing, kind of to make me feel better, so I can see some progress. When there isn't any progress I just want to pile on the punishments, make him behave. Now I see that it needs to be more about him, doesn't it?

SW: Your motivations are really good, but yes I don't think you will be able to punish him into being good.

Sue: Thank you, I really think this might be a way forward, but I mustn't rush it. I need you to help me to take one step at a time.

SW: Sure, we can figure this out together too. You are still going to have plenty of strong feelings provoked by James and his behaviours. It's one step at a time for all of us isn't it?

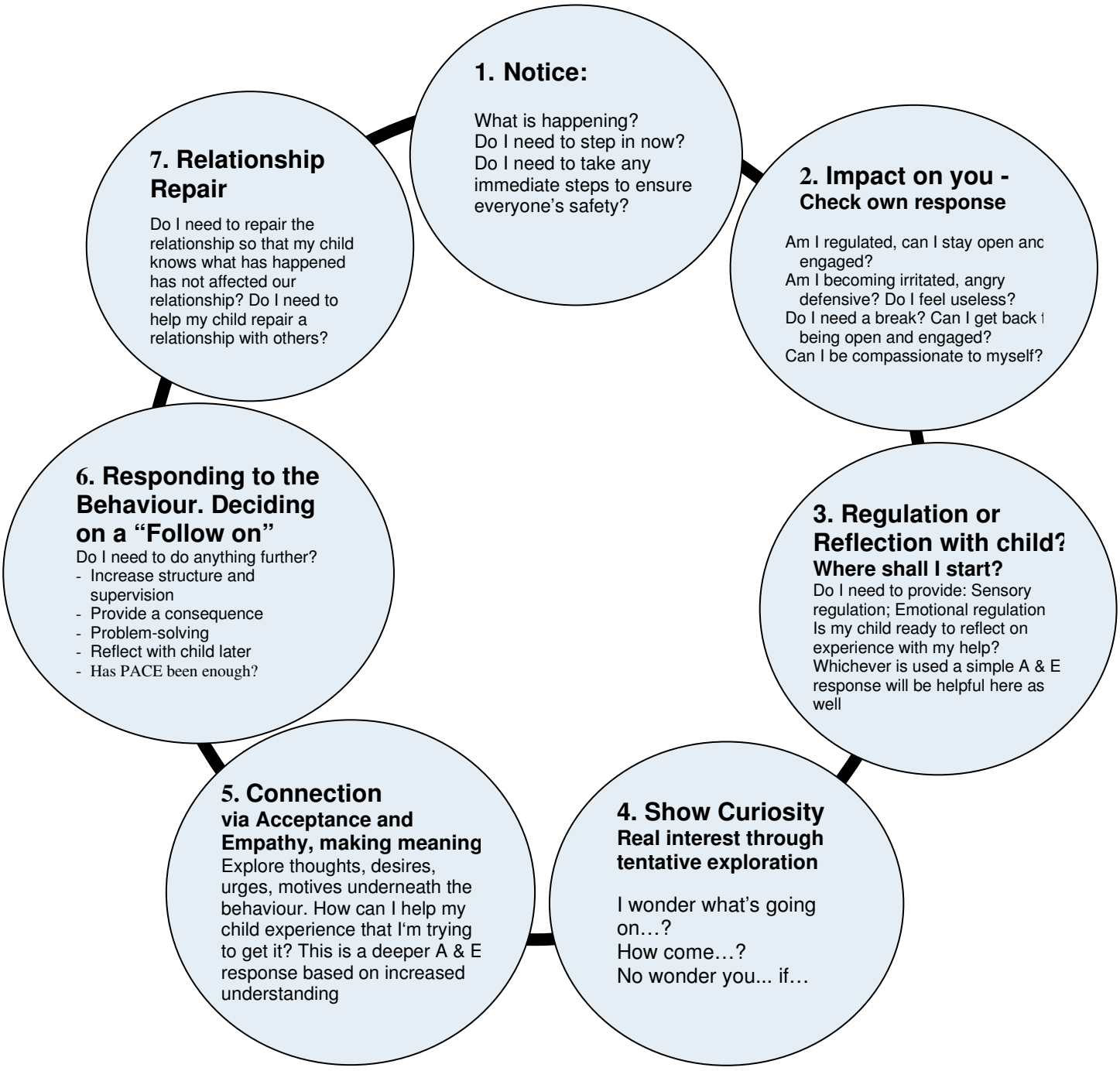
PARENTING IN THE MOMENT[3].

Connection first before responding to behaviour

All with an attiude and atmosphere of PACE

"Two Hands" but always together

This cycle demonstrates some steps that can be helpful to take when parenting a child. By keeping these steps in mind, it can be easier to stay open and engaged with the child rather than becoming irritated or defensive within parenting. This in turn helps to make an emotional connection with the child before providing a response to his behaviour. So easy to say and so hard to do. When a parent does this, their child is more likely to experience acceptance of who they are underneath their outward behaviour alongside experiencing the safety that a combination of empathic boundaries and discipline can provide.



[3] In Golding K. S. (2017) Foundations for attachment training resource JKP.

Kim would like to acknowledge staff at Clover Childcare, Norfolk for help developing this .

SUPPORTING A CHILD'S BEHAVIOUR AND EMOTIONAL LIFE

Making sense of why some parenting approaches might not work well	
What might motivate a securely attached child to behave in certain ways or change their behaviour?	**What might motivate an insecurely attached child to behave in certain ways or change their behaviour?**
Incentives can include:	**Incentives can include:**
Pleasing the people you care about	Causing emotional pain to others
Feeling that you have really achieved something	Keeping a negative view of themselves going
Having other people recognise all your effort	Needing no-one and showing people you care about that you need nothing from them
Gaining money, things you want or nice food	Avoiding being praised
Enjoying hearing people saying nice things about you	Engaging in and winning power struggles and feeling in control of the feelings/behaviours of others
Feeling you have proof that you are just a little better than someone else at something	Avoiding experiences of mutual laughter and fun
Having fun with others	Confirming that you really are worthless, bad or unlovable (or might start to hope or believe that things might be different)
A reminder that you are O.K. really	Avoiding emotional engagement with others Avoiding feeling loved or special to someone
	Avoiding having to ask for comfort, help or favours

SUMMARY - Supporting a child's behaviour and emotional life

1. **Help parents with emotional regulation that supports reflection to enable co-creation of narratives*:*** Non-judgmental, accepting care giving to the parents/carers, using PACE, promotes open engagement. This helps develop the safety and trust required for parents to express, rather than avoid, their feelings of rejection, shame and anger to the adults who support them.

2. **Making sense of behaviour - Understanding the meaning of behavior of both parent and child:** Help parents understand, accept and make sense of the strategies and defenses child has developed to deal with the impact of their trauma and loss**.** Respect child's defenses while gently challenge their continuing usefulness in the present. They developed for good reasons and may have been helpful for child in the past.

3. **Connection before Direction - or before setting limits**: Solving problems (such as refusing to attend school), addressing tasks (such as a contact decision) or addressing behaviour (such as self harmed last night) are more effectively done when:
    - Adults have understood the child more
    - The adult is experiencing some empathy for child
    - The child experiences adults as trying to make sense of him or her so the child is more likely to be open and engaged.

Connection with Behavioural Support: Parenting Principles

PRINCIPLE ONE: PACE, a consistent feature. Discipline as needed.

PACE before discipline: Helps child to feel emotionally connected; unconditionally loved.

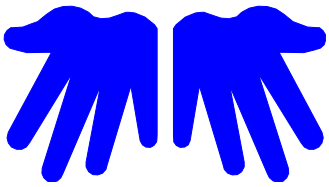
PACE with discipline: Helps to maintain this connection when the child is at her most vulnerable; experiencing shame, and fear.

PACE following the discipline: Provides child with continuing sense of being unconditionally loved; repairing ruptures in the relationship.

Trust and Mistrust
Children need connection from birth. This connection builds trust in the caregiver and helps the child experience being loved unconditionally. As the child matures and requires boundaries and discipline they manage this correction because the trust has been built. When connection and correction have to be done at the same time, children struggle with the correction as it is built on a foundation of mistrust rather than trust.

PRINCIPLE TWO: Two hands of parenting;
Connection with Correction[4] and no Correction without Understanding

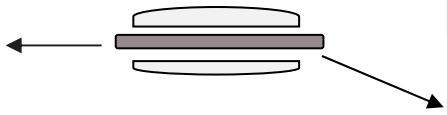
Hand One*:* provides warmth and nurture and allow children appropriate autonomy matched to their developmental age. Holds the curiosity about child's experience.



Hand Two: provides structure, and boundaries.

PRINCIPLE THREE: Parenting Sandwich

Discipline
Remain calm, warm and sympathetic, whilst being clear about the boundary (what isn't allowed) and the consequence (if – then). Avoid anger.



Attunement
Use empathy to communicate your understanding and sympathy for how the child is feeling.

Relationship Repair
Help the child to know they are still loved and cared for. The relationship is stronger than this episode.

[4] Note: the term 'correction' is used to denote parenting to teach prosocial behaviours with warmth, appropriate limits and boundaries. No association with punishment is implied.

Connection with Behavioural Support: Parenting Principles

PRINCIPLE FOUR: Adult takes responsibility for relationship with child

Don't punish with the relationship
Take breaks when needed if it is practically possible.
Take responsibility for relationship repair.

PRINCIPLE FIVE: Understanding first

Don't lecture and delay problem solving; Don't rush to reassure.
Reassure to give hope for the future, rather than to make yourself feel better.

PRINCIPLE SIX: Provide appropriate level of structure and supervision

Notice child's emotional maturity and adjust expectations in line with this. If the consequences are piling up it is a sign that the child needs increased structure and supervision alongside empathy.

PRINCIPLE SEVEN: Help the child to manage shifts between playfulness and parental authority.

Mistrusting children struggle with parental authority. When a parent needs to use their authority for keeping the child safe; providing a boundary and structuring the environment the child will revert to controlling behaviours.
Shifting from playful times with parents ('companionship mode') to a 'parental authority mode' is difficult, Baylin & Hughes (2016). These relational transitions can lead to very rapid shifts in the child towards anger and meltdown. The parent needs to find a way to stay open and empathic to the child's struggles in letting parents have a benevolent authority over them.

Managing escalating arousal

Working with the brain

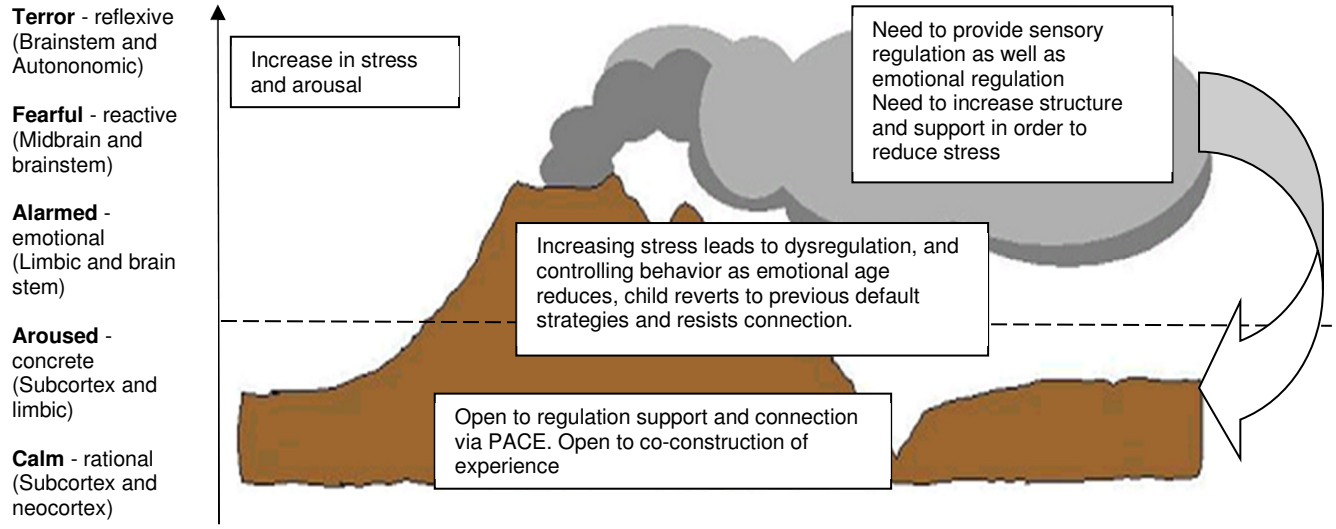
Mental State	Cognition Primary/secondary	Brain areas
Calm	Abstract	Neocortex/Subcortex
Aroused	Concrete	Subcortex/Limbic
Alarmed	Emotional	Limbic/Midbrain
Fearful	Reactive	Midbrain/brainstem
Terror	Reflexive	Brainstem/Autonomic

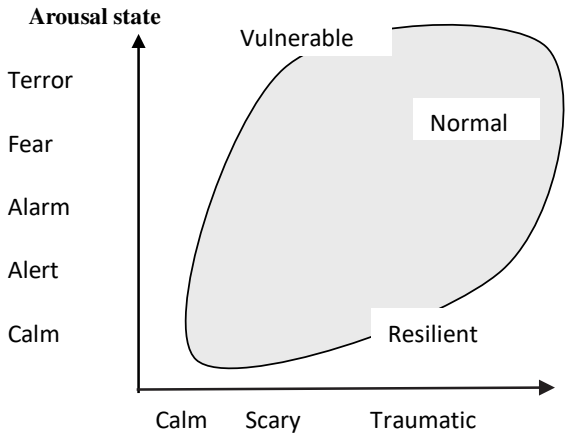
(adapted from Perry, 2006)

"Knowing where a child is on the arousal continuum – accurately knowing the child's internal state – can help us determine when to talk, and when to stop talking and start using simple, nonthreatening interactions to quiet and contain the escalating child." (Perry, 2006)

Role of regulation:

Behavioural support is better described as regulation support. Until a child experiences both sensory and emotional regulation they are unlikely to have their cognitive brain on line and to be able to make good behavioural choices. Parents need to be thoughtful about when to use regulatory strategies, when to have PACE as the main focus, and when to use behavioural support.





(from Bruce Perry, 2007 Working with Child Trauma and Recovery, SACCS Conference, London.)

21 "S"s - Parental Activities, Goals and Means of Achieving Them

"S"s to Increase:

1. **Self-Care:** The parents' need for relationships, advocacy, services, successes, breaks
2. **Safety:** Presence, predictability and the remaining 12 points
3. **Structure**: Not rigid, reduces transition stress, "free time" can be "anxiety time"
4. **Supervision:** A gift, not a punishment, a relaxed, aware, presence
5. **Success:** Does not learn from mistakes; needs an "error-free environment" with expectations matched to developmental age; reduced shame associated with mistakes
6. **Soothing:** Gentle, gradual persistence, perhaps represented by soft toy
7. **Smiles:** A positive attitude within home - the emotional atmosphere
8. **Story-telling:** A manner of relating without lectures and rational processing
9. **Seeking Meaning**: What does the behavior mean? Make sense of it first
10. **Sense of Humor**: To generate hope, maintaining perspective, a way of being close when signs of affection frighten the child.
11. **Sensory Integration**: Often develop in conjunction with attachment
12. **Stretching**: Being prepared to expand one's parental skills, interventions
13. **Sorry:** Modeling making mistakes and repairing the relationship
14. **Sleep**: Crucial for functioning of all. Unique bedtime routines need to be created

"S"s to Decrease:

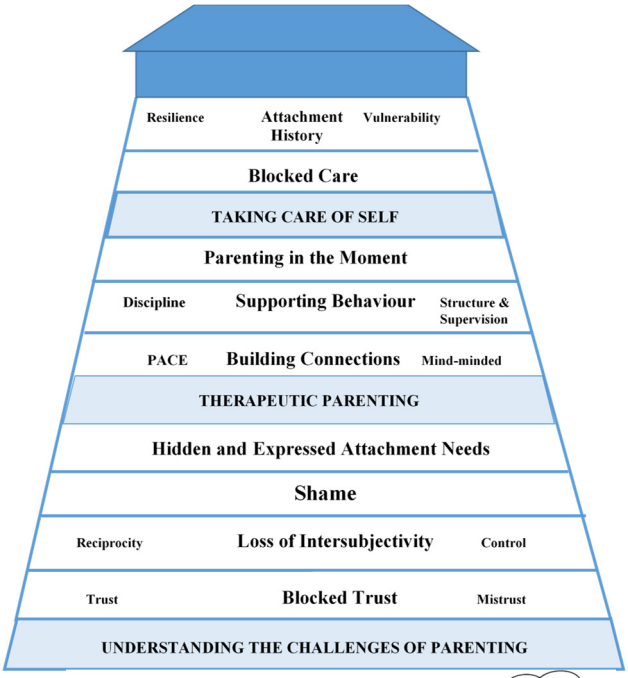
1. **Shame**: Source of denial, opposition, rage, inability to trust and resolve trauma
2. **Stimulation**: Overstimulation by many routine, interesting, exciting events which leads to dysregulated emotion, thinking, and behavior
3. **"Should":** Advice from others to raise the child based on his chronological age
4. **Shouting:** Habitual misbehaviors often lead to habitual anger, shouting, and negative emotional atmosphere. Necessary anger needs to be an "I-message" that is clear and brief and is immediately followed by repair
5. **Sarcasm:** Often a substitute for anger; can be just as destructive to a developing attachment
6. **Seclusion**: Isolation triggers rejection and abandonment experiences. Isolation prevents the opportunity to co-regulate emotional states
7. **Smacking:** Likely to trigger past experiences of abuse and neglect and greatly impair the development of trust necessary for attachment security

Basic Assumptions to Suggest to Parents of Traumatized, Attachment-Resistant Children

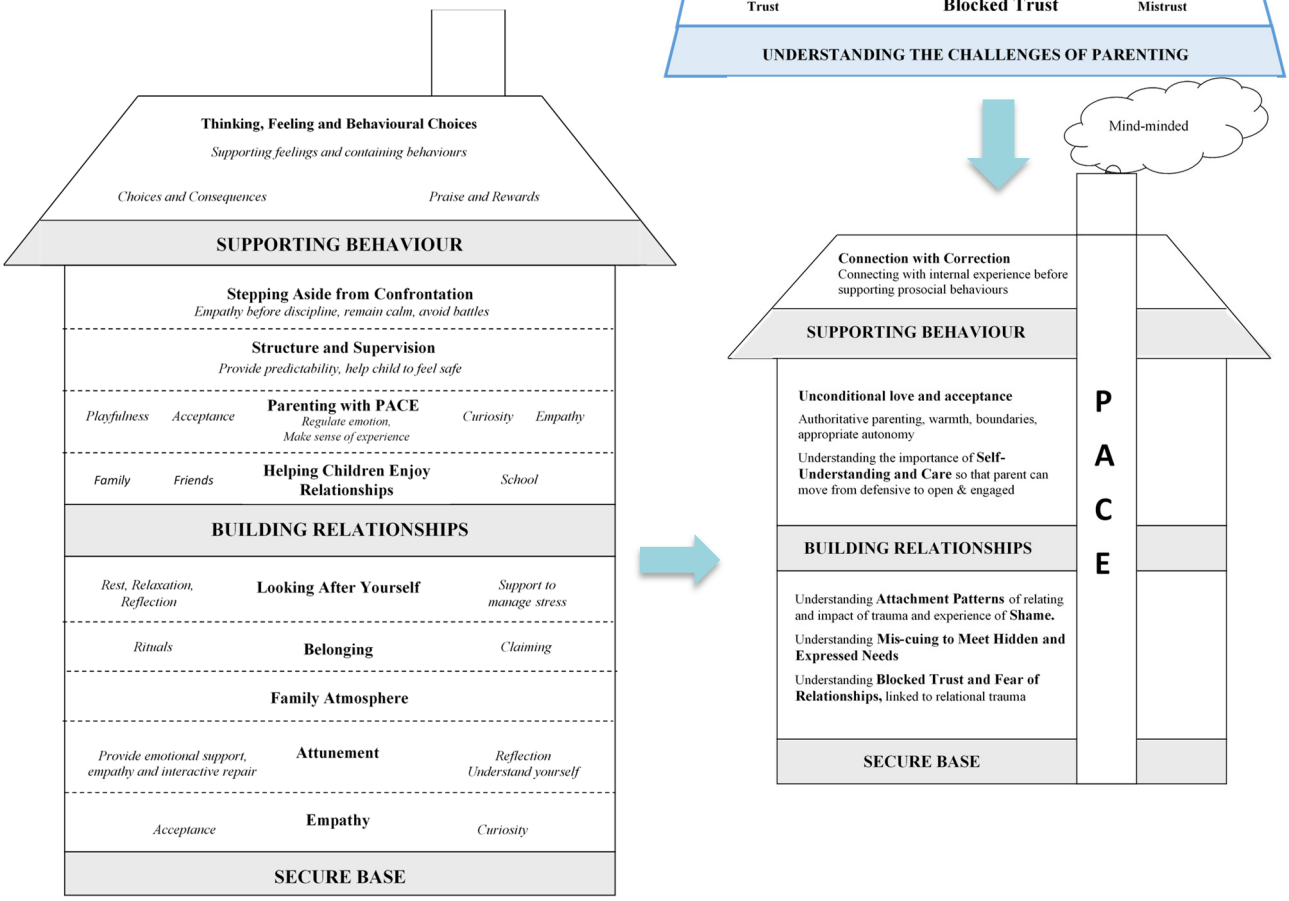
1. Both you and your child are doing the best you can.
2. You both—at a deep level—want family life to improve.
3. Your lives, as they are lived now, are often very difficult for you both.
4. Your child is trying to establish safety by **controlling** the other.
5. Your child tries to be safe by **avoiding** everything that is stressful & painful.
6. His attacks (emotional, verbal, physical) on you & his resistance to you, reflect his fear of your motives for your nurture & discipline of him, his poor affect regulation, fragmented thinking, pervasive sense of shame, inability to trust, and lack of behavioral controls.
7. For her to change, she will need you to accept, comfort, & teach her.
8. You will need to validate his sense of self, while teaching him important developmental skills.
9. You will need to come to know her developmental age, and fine tune your expectations to match that age so that she will have success, not failure. Your physical and psychological presence are the foundation of your comforting & teaching her. Structure and supervision are crucial.
10. Under stressful emotional conditions, he will regress and revert to his solitary defenses that he used to survive in his terrifying, lonely past.
11. You will both have to work hard to learn how to live well. You cannot do her work for her, nor can you save her. You can comfort & teach her.
12. You will need support and consultation from trusted others if you are to be able to successfully comfort & teach him. You will make mistakes and you need to face these, learn from them, and continue. Your own attachment/parenting histories will often be awakened as you raise your child. You will have to address anything from your past that has not been resolved in order to persist in your difficult parenting activities and responsibilities.

MODELS FOR THERAPEUTICALLY PARENTING CHILDREN[5]

The Foundations Model of Parenting



The House Model of Parenting



[5] These are complimentary models developed by Kim for her groupwork parenting programmes. 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 and Golding K. S. (2017) Foundations for attachment training resource. The six-session programme for parents of traumatized children. London: Jessica Kingsley Publishers

PARENTING PROFILE FOR DEVELOPING ATTACHMENT

Respond from 1-5. 1 represents perception of very little; 5 perception of a great deal of the characteristic/skill. Focus on adult's abilities, not whether or not the child is receptive to the interaction.

	Self	Partner
1. Able to maintain a sense of humour.		
2. Comfortable with giving physical affection.		
3. Comfortable receiving physical affection.		
4. Ready to comfort child in distress.		
5. Able to be playful with child.		
6. Ready to listen to child's thoughts and feelings.		
7. Able to be calm and relaxed much of the time.		
8. Patient with child's mistakes.		
9. Patient with child's misbehaviour.		
10. Patient with child's anger and defiance.		
11. Patient with child's primary two symptoms.		
12. Comfortable expressing love for child.		
13. Able to show empathy for child's distress.		
14. Able to show empathy for child's anger.		
15. Able to set limits, with empathy, not anger.		
16. Able to give consequence, regardless of his response.		
17. Able and willing to give child much supervision.		
18. Able and willing to give child much "mom-time".		
19. Able to express anger in a quick, to the point, manner.		
20. Able to "get over it" quickly after conflict with child.		
21. Able to allow child to accept consequence of choice.		
22. Able to accept, though not necessarily agree with the thoughts and feelings of your child.		
23. Able to accept, though you may still discipline, the behaviour of your child.		
24. Able to receive support from other adults in raising this difficult child.		
25. Able to acknowledge failings and mistakes in raising this difficult child.		
26. Able to ask for help from people you trust.		
27. Able to refrain from allowing your child's problems to become your problems.		
28. Able to cope with criticism from other adults about how you raise your child		
29. Able to avoid experiencing shame and rage over your failures to help your child.		
30. Able to remain focused on the long-term goals.		

What is DDP informed residential child care?[6]

Residential child care is unique in that it provides a collaborative ethos involving a team of people who are parenting the young people. A DDP approach allows the team to follow the same attitude helping them to emotionally connect with the young people and therefore enriching these relationships. This encompasses all relationships and connections between the adults; the adults and young people and facilitating this between the young people. Staff develop an understanding of their own reactions and triggers so that they can remain reflective even when young people are in crisis. This provides the children with a consistent experience of reciprocity and being kept in mind. This incorporates the principles of DDP into daily interactions which helps to build the relationships and from this to lead the young people to develop an understanding of their current and past experience and, over time, to give them a more hopeful, positive future.

This can be achieved by:

- Encouraging self-reflection for staff at the start of shift so that they move into the shift understanding their own internal experience and how this might impact on their ability to remain open and engaged with the young people.
- The change over focuses on understanding the emotional tone of the home; and the young people's current emotional experience; encouraging acceptance of this.
- Staff take the time to reconnect with each individual young person as they work their shift so that their relationships are intersubjectively focused (relationship based) with an attitude of PACE.
- Colleagues are supportive and use the DDP principles with each other.
- Staff help the young people to experience the world safely and with enjoyment.
- Staff take the time to sit with uncomfortable feelings and help the young people to develop their ability to regulate these through the experience of co-regulation; and reflect upon and understand these through the experience of co-construction
- Staff ensure safe spaces are made so that young people can explore their difficult emotions within the context of living within a household and the multiple tasks this involves.
- Staff accept that there will be ruptures to their attunement with the children both because of need to provide discipline and because of the impact on the children of their traumatic histories which in turn impacts on the staff. Staff will ensure that relationship repair occurs at these times.
- Staff keep in mind the four key areas of fear for the children (Mistrust; fear of reciprocity involved in intersubjective relationships; experience of shame and attachment fears which lead to miscuing of needs). An understanding of these help staff to remain compassionate, open and engaged towards the children and ensure that any consequences focus on reparation of relationships and building of trust.

'I know that I am using DDP because I feel more comfortable, less anxious and more confident when at work. I feel a connection between me and the young people. Through this connection the young people are more able to accept nurture, my help, advice and support.'

[6] Developed by staff working within Clover Childcare Services in Norfolk, UK

The Experience that is DDP[7]

At its core, DDP is an experiential therapy. The focus is on the here and now, you and me, and the content of the developing conversation is experienced affectively by both the practitioner and the child and/or parent. What is the experience that occurs in DDP? A basic tenet of DDP is "Trust the Process." What is the process of DDP that we might be wise to trust?

A RE-THINK on the Importance of INTERSUBJECTIVITY

Within intersubjectivity our separate experiences are interwoven both in my mind and in your mind. When the experiences differ, one is not right with the other being wrong. They simply are different, and both are still in my mind. My experiences of you become part of your experiences of yourself, and your experiences of me become part of my experiences of myself. You trust me to the extent that you trust that the experiences of yourself that are in my mind will remain in my mind with acceptance and understanding. **As the trust expands, you are likely to allow more of your experiences of yourself to enter into my mind, responsive to my open invitation and the safety of my acceptance**.

For Relationship Reciprocity, there must be space in the mind of each person for the experience of the other person. In situations of abuse and neglect there is no space for the experience of the child in the mind of the abuser. With authoritarian parents there is no space for the mind of the child in their relationship with their child. In their mind is the belief that their child's position should be one of obedience and submissiveness-which they might label as "respect" rather than their child having a place in influencing the parent. This parent knows best so that all that is necessary is for their mind to be aware of the child's behavior, not the child's mind. They are demanding respect but are not respectful of their child's mind. In other cases of neglect, the parent's mind is so full of their own unresolved issues or desires and wishes that there is again no space for the mind of the child.

Children who have been abused and neglected experience pervasive shame. The only account they can develop for the meaning of the parents' abusive or indifferent behaviors is "I am bad/stupid/not good enough". **These children also have shame that comes from the experience that their mind is not worth having a space in the mind of their parents.** Their mind was experienced as being limited, irrelevant, selfish, too much or even non-existent. Their parent not only did not see its value, their parent did not even see it. And then when the infant or child asks the question-"who am I?" -the core question of development -the answer that comes back is you are bad, shameful, an object for my use, disgusting, or nothing.

That is why as a DDP practitioner you must **HELP THE CHILD TO SEE HOW INTERESTED YOU ARE IN THEIR EXPERIENCE and mind. You have space in your mind for ALL of their experiences, including those that involve self-loathing or disgust that arrived from their traumatic experiences.** Through attentively holding their experience in your mind:-hearing, witnessing, exploring, validating, and bearing their experience you develop WITH them new experiences about who they are -a self that is lovable, courageous, inventive, delightful, safe.

The DDP practitioner must communicate that she has space for the child's experience by conveying a habitual state of being open and engaged with the child-a mind open to their mind. Previously I used to say "be ready to be intersubjectively with the child the moment you enter the waiting room to meet them". Now I realize you must be open to the child's mind prior to the moment of meeting them in the waiting room. Neurobiology tells us that the child is likely to sense your interest in her nonverbally in the first ¼ second after meeting you-and you need to be ready. Abused and neglected children with minds full of shame will be quick to misread ANY ambivalent signals you might be sending as proof that you think they are bad or annoying or not

[7] This article is a summary of the keynote presentation that Dan Hughes made on 29 September 2017 in Worcester, UK. for the launch of DDP Connects UK.

someone you want to be with today. You might run through this check (before walking to the waiting room):

1. Be aware if your mind is somewhere else and if you are able to set that aside and be present with the child.
2. Recall the child's history in order to build compassion which will help to accept the experiences that underlie the child's defensive or angry manner of engaging you. (It is neurologically impossible for a child's angry expressions to evoke empathy.

   Empathy— centered deep in the prefrontal cortex and anterior cingulate cortex within the insula—is often our response to distressed, vulnerable, emotions.

   Compassion involves more reflective systems in the medial prefrontal cortex that enable us to recall the stressful events that are likely to be underneath the child's anger. Compassion motivates us to assist the other, enabling us to accept their anger. This acceptance is likely to activate a bit of distress or vulnerability in the child and this then evokes our experience of empathy.)
3. Recall the typical challenging behaviors of the child you are about to see so that you are ready to be able to accept them without becoming defensive.
4. **Be aware of your own bodily state**-take a breath and be prepared to convey open engagement in your face, voice, gestures as you enter the waiting room.

Blocked Care—when it is hard to maintain the neurobiological activities of caregiving due to a lack of a response to your caregiving by the child. (These activities are designed for reciprocity)

The risk of blocked care is often increased by the child relating with the unconscious intention of controlling a parent or therapist's emotions through making them feel angry, anxious, inadequate or wanting to give up.

If the parents/therapists are able to consistently be aware of this normal reaction, inhibit it, accept it, and remain open and engaged. Then when they experience compassion for the child over her history, and discover the meaning of the child's behaviors, the child may well start to move toward them-sensing they are held compassionately in the mind of the other.

For the **Co-Regulation of Affect & the Co-Creation of Meaning** involving all content, past and present,

We start with two minds, joined intersubjectively:

Intention: I express Understanding, Acceptance, and Support which the child accepts.

Attention: I give expression to events of past held in my mind with Compassion and the child focuses on them with me.

Attunement: My experiences expressed nonverbally are synchronized with the child. Three possible intersubjective experiences emerge when an event from the past is discussed.

- The child recalls the experience, with congruent nonverbal expressions, which evokes a synchronized nonverbal response from me.
- I reflect on a possible experience—with congruent nonverbal expressions—that the child may have had, this evokes a synchronized nonverbal response from the child.
- The child recalls the experience, without congruent nonverbal expressions. I reflect on a possible experience, **with congruent nonverbal expressions**—that the child may have had, this evokes a synchronized nonverbal response from the child. (This sequence is needed when child has dissociated from the affective component of the experience of the event.)

Attachment, Companionship, and Dominance are 3 neurobiological relationship systems.

ATTACHMENT: Unconditional acceptance, the child is within my mind "for better or for worse".

Supporting safety with comfort and interactive repair.

COMPANIONSHIP: becoming intersubjective, bringing the mind of the other to the forefront, working out joint best-interests.

Supporting autonomy and socialization with Direction.

DOMINANCE: Firm Guidance for the child as to what is best for them.

Giving Direction with Compassion.

All three systems function best in developing a strong relationship when they are intersubjective. In ordinary parenting the strongest parent-child relationships have flexible movements between, and integration of, the three systems. In therapeutic parenting-with a child whose behaviours constantly reflect a mind/brain set to defend or attack, flexible integration of these three systems becomes even more crucial and a whole lot more challenging. We are often aware of the need to support parents to open up their minds to the vulnerabilities of their child hidden beneath the control and defiance (through opening our minds to the parents' experience). I am also aware at times of the need to support parents to strengthen their dominance system which may be compromised by their compassion for all their child has been through-so they resist setting limits because they don't want to "hurt" their child further and at other times because something from their attachment history is making it hard for them to feel secure in being able to take the lead and guide their child and to set appropriate limits.

Being **OPEN & ENGAGED** and **RELAXED & CONNECTED**: The Rhythm of Being together

Open and engaged is the neurobiological state described by Stephen Porges that contrasts with the defensive state of fight-flight-freeze or the less extreme defensives states of avoidance, excuses, or viewing your experiences as being right and the other's as being wrong. Being open and engaged is activated when the person is feeling safe and does not have to be focused on self-protection. It is present when the person feels accepted, and not evaluated. Acceptance is conveyed with rhythm and modulated nonverbal vocal expressions in conversations with the other. The DDP practitioner's influence is determined by the ability to remain in the open and engaged state when the child is defensive, evoking a similar open and engaged state in the child. This leads to regulated affective states and reflective functioning about current and past traumatic and shameful events.

While **Open and Engaged intersubjective states** are crucial for therapeutic momentum and integration, it is not the only necessary intersubjective state for the DDP practitioner to maintain in the session. Being open and engaged with a defensive controlling child, by overriding your brain's natural defensive response to the child's attacks is **TRANSFORMATIVE** to the child's sense of self and the meanings of the traumatic events in his life. (and also transformative for the therapist/parent's experience of the child and of herself.)

But in the natural ebb and flow of therapeutic conversations and relationships, there is need for the practitioner/parent and child to also have intersubjective states where they are **Relaxed and Connected**[8]. These states precede and follow the more active and curious open and engaged states. These states represent much more than simply 'taking a break' from the hard work of therapy. They have value in their own right as states of being-together, enjoying the moment, feeling the safety of relaxing with someone you enjoy and trust. And this relaxed and connected experience of being in the mind of the other contributes to the **CONSOLIDATION** of a new sense of self emerging through the transformative work of the more active aspects of DDP; a self that can be enjoyed and one that is less contaminated by the toxic shame of abuse and neglect.

[8] Dan acknowledges Deborah Page for suggesting the phrase 'relaxed and connected' and for suggesting that 'open and engaged' facilitated transformation while 'relaxed and connected' facilitated consolidation.