

# **ATTACHMENT FOCUSED FAMILY THERAPY:** *WHAT IS DYADIC DEVELOPMENTAL PSYCHOTHERAPY?*



**New York State Citizens' Coalition for Children  
22<sup>nd</sup> Annual Foster Care and Adoption Conference**

**May 6, 2011**

**Courtney Rennicke, Ph.D.**

# ATTACHMENT FOCUSED FAMILY THERAPY: *WHAT IS DYADIC DEVELOPMENTAL PSYCHOTHERAPY?*



## Overview

- THE NEED: What emotional, developmental, behavioral, and attachment related issues does DDP address?
- THE WHAT: What are the main concepts that inform DDP?
- THE HOW: How does DDP work in the therapy session?



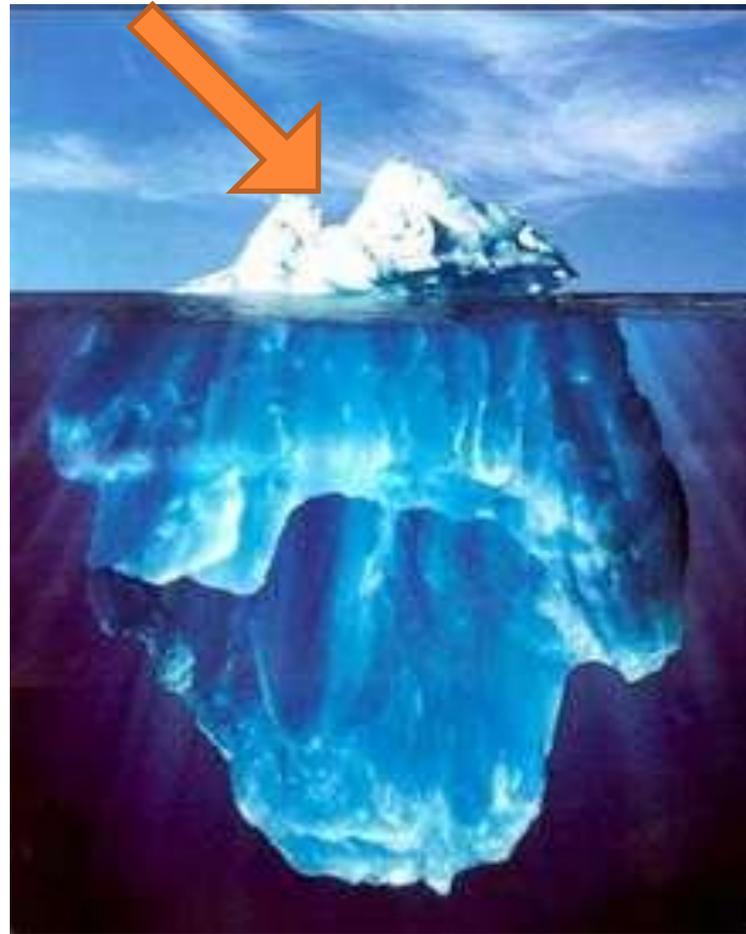


# THE NEED FOR ADOPTION/FOSTER CARE SPECIFIC TREATMENTS

Targeting Complex Relational Trauma

# THE NEED FOR DDP: WHAT IS SURFACE & WHAT IS DEEP?

- “Many problems of traumatized children can be understood as efforts to minimize objective threat and to regulate their emotional distress. Unless *caregivers* understand the nature of such re-enactments they are *likely to label the child as ‘oppositional,’ ‘rebellious,’ ‘unmotivated,’ or ‘antisocial.’*” (van der Kolk et al., 2005).
- “When *professionals* are unaware of children’s need to adjust to traumatizing environments and expect that children behave in accordance with adult standards of self-determination and autonomous, rational choices, these maladaptive behaviors tend to inspire revulsion and rejection. *Ignorance of this fact is likely to lead to labeling and stigmatizing children for behaviors that are meant to ensure survival.*” (van der Kolk et al., 2005)



# THE NEED FOR DDP: DIAGNOSES/DISORDERS

- **Complex relational trauma** (Cook et al., 2005)
  - PTSD alone does not explain the effects of maltreatment, abuse, separations from caregivers and trauma.
  - Impact of ongoing abuse, neglect, and interpersonal trauma in early life has multiple implications for disruptions in 7 domains of development.
- **Developmental Trauma Disorder** (van der Kolk et al., 2005)
  - Attempt to create a diagnosis that reflects the consistent and predictable consequences for children with complex relational trauma histories.
- **Reactive Attachment Disorder (RAD)** (APA, DSM-IV-TR, 2000)
  - Current psychiatric diagnosis in the DSM
  - Is descriptive of the attachment disruptions, but does not include the other domains of disrupted development.



# THE NEED FOR DDP: COMPLEX RELATIONAL TRAUMA

## Domains of Impairment in Children Exposed to Complex Relational Trauma (Cook et al., 2005)

### I. Attachment

- Problems with boundaries
- Distrust and suspiciousness
- Social isolation
- Interpersonal difficulties
- Difficulty attuning to other people's emotional states
- Difficulty with perspective taking

### II. Biology

- Sensorimotor developmental problems
- Analgesia
- Problems with coordination, balance, body tone
- Somatization
- Increased medical problems across a wide span (eg, pelvic pain, asthma, skin problems, autoimmune disorders, pseudoseizures)

### III. Affect regulation

- Difficulty with emotional self-regulation
- Difficulty labeling and expressing feelings
- Problems knowing and describing internal states
- Difficulty communicating wishes and needs

### IV. Dissociation

- Distinct alterations in states of consciousness
- Amnesia
- Depersonalization and derealization
- Two or more distinct states of consciousness
- Impaired memory for state-based events

### V. Behavioral control

- Poor modulation of impulses
- Self-destructive behavior
- Aggression toward others
- Pathological self-soothing behaviors
- Sleep disturbances
- Eating disorders
- Substance abuse
- Excessive compliance
- Oppositional behavior
- Difficulty understanding and complying with rules
- Reenactment of trauma in behavior or play (eg, sexual, aggressive)

### VI. Cognition

- Difficulties in attention regulation and executive functioning
- Lack of sustained curiosity
- Problems with processing novel information
- Problems focusing on and completing tasks
- Problems with object constancy
- Difficulty planning and anticipating
- Problems understanding responsibility
- Learning difficulties
- Problems with language development
- Problems with orientation in time and space

### VII. Self-concept

- Lack of a continuous, predictable sense of self
- Poor sense of separateness
- Disturbances of body image
- Low self-esteem
- Shame and guilt



# THE NEED FOR ADOPTION/FOSTER CARE SPECIFIC TREATMENTS: DEVELOPMENTAL TRAUMA DISORDER

## A. Exposure

- Multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma.
- Subjective experience of rage, shame, fear, resignation

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

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

- Emotional
- Somatic/physiological
- Behavioral
- Cognitive
- Relational
- Self-attribution

## C. Persistently Altered Attributions and Expectations

- Negative self-attribution
- Distrust of protective caregivers
- Loss of expectancy of protection for others
- Loss of trust in social agencies to protect
- Lack of recourse to social justice/retribution
- Inevitability of future victimization

## D. Functional Impairment

In educational, familial, peer, legal, and vocational domains

From van der Kolk et al. (2005).



# THE NEED FOR DDP: REACTIVE ATTACHMENT DISORDER

DSM-IV only specifies 1 type of attachment disorder: **313.89 Reactive Attachment Disorder of Infancy or Early Childhood (RAD)**

**Markedly disturbed and developmentally inappropriate social relatedness** in most contexts, beginning before age 5 years, as evidenced by either (1) or (2) due to pathogenic care:

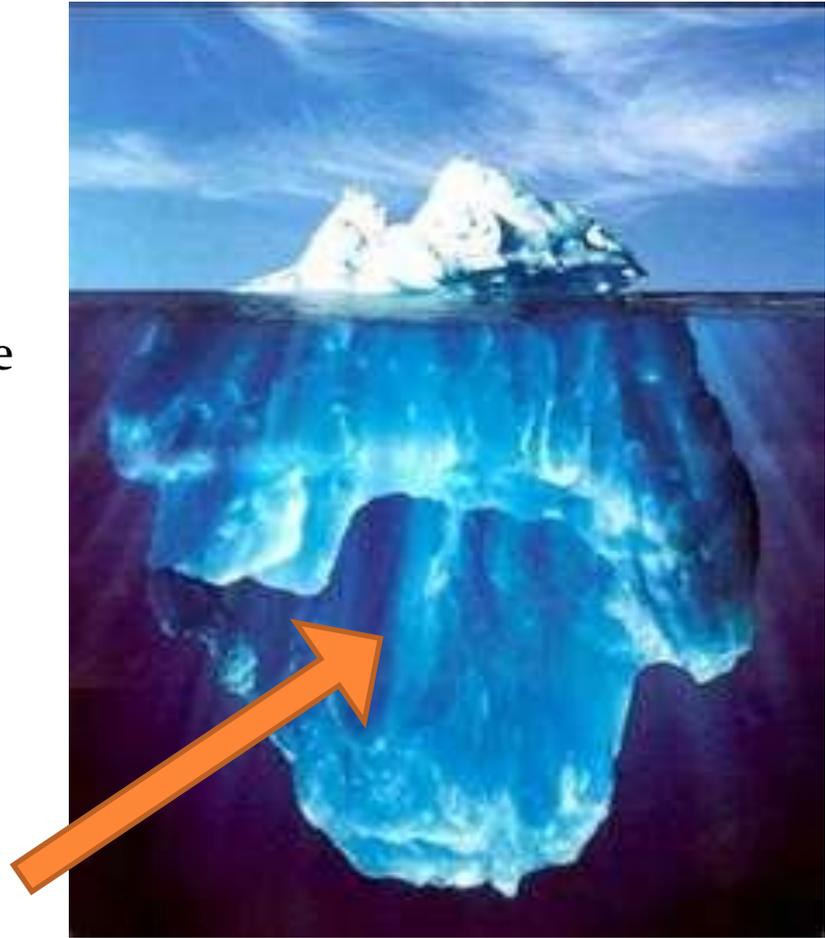
(1) **Inhibited Type:** persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness)

(2) **Disinhibited Type:** diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures)



# THE NEED FOR DDP: UNDERNEATH THE SURFACE

- “When caregivers are emotionally absent, inconsistent, frustrating, violent, intrusive or neglectful, children are likely to become intolerably distressed and unlikely to develop a sense that the external environment is able to provide relief.”
- With their repeated trauma histories – “when exposed to reminders of a trauma (e.g. sensations, physiological states, images, sounds, situations), [the child] tends to behave as if they were traumatized all over again – as a catastrophe.”



From van der Kolk et al. (2005).

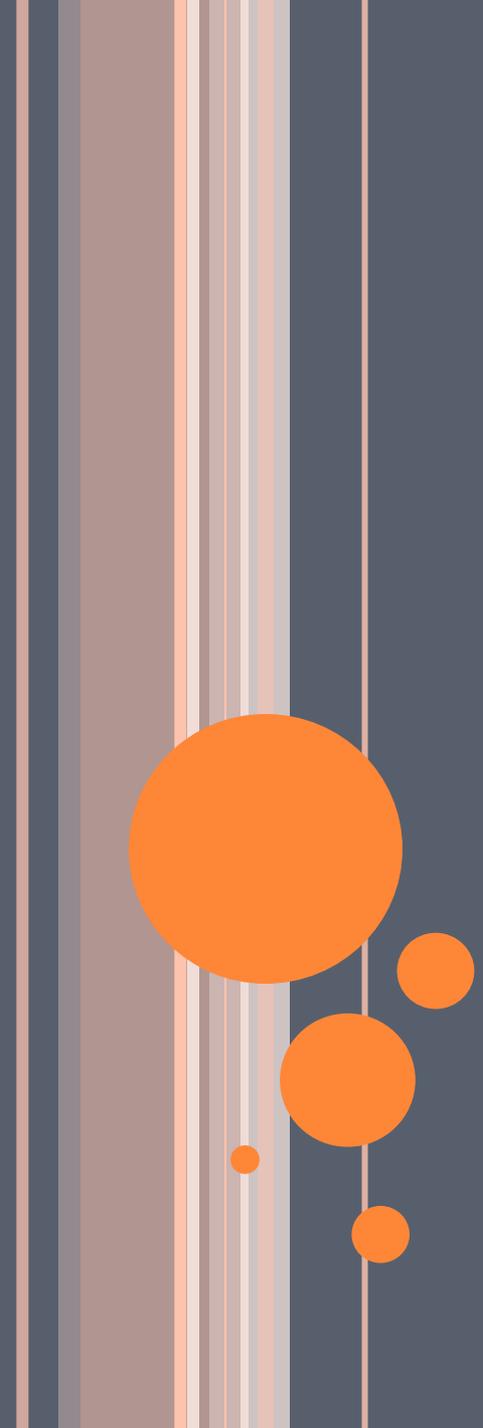


# THE NEED FOR DDP: COMPLEX RELATIONAL TRAUMA



6 Core components of treating complex relational trauma (Cook et al., 2005):

1. **Safety** (e.g. enhance internal and environmental sense of safety)
2. **Self-regulation** (e.g., ability to calm down)
3. **Self-reflective information processing** (e.g. reflect on past and present experiences, make plans and decisions)
4. **Traumatic experience integration** (e.g. resolving traumatic memories, developing ways to cope with traumatic triggers)
5. **Relational engagement** (e.g., restore and create effective ways to attach to caregivers)
6. **Positive affect enhancement** (e.g., building self-esteem, imagination, and capacity to experience pleasure)



# BUILDING BLOCKS OF DYADIC DEVELOPMENTAL PSYCHOTHERAPY

The WHAT: Attachment & Intersubjectivity

# THE WHAT OF DDP: ATTACHMENT THEORY

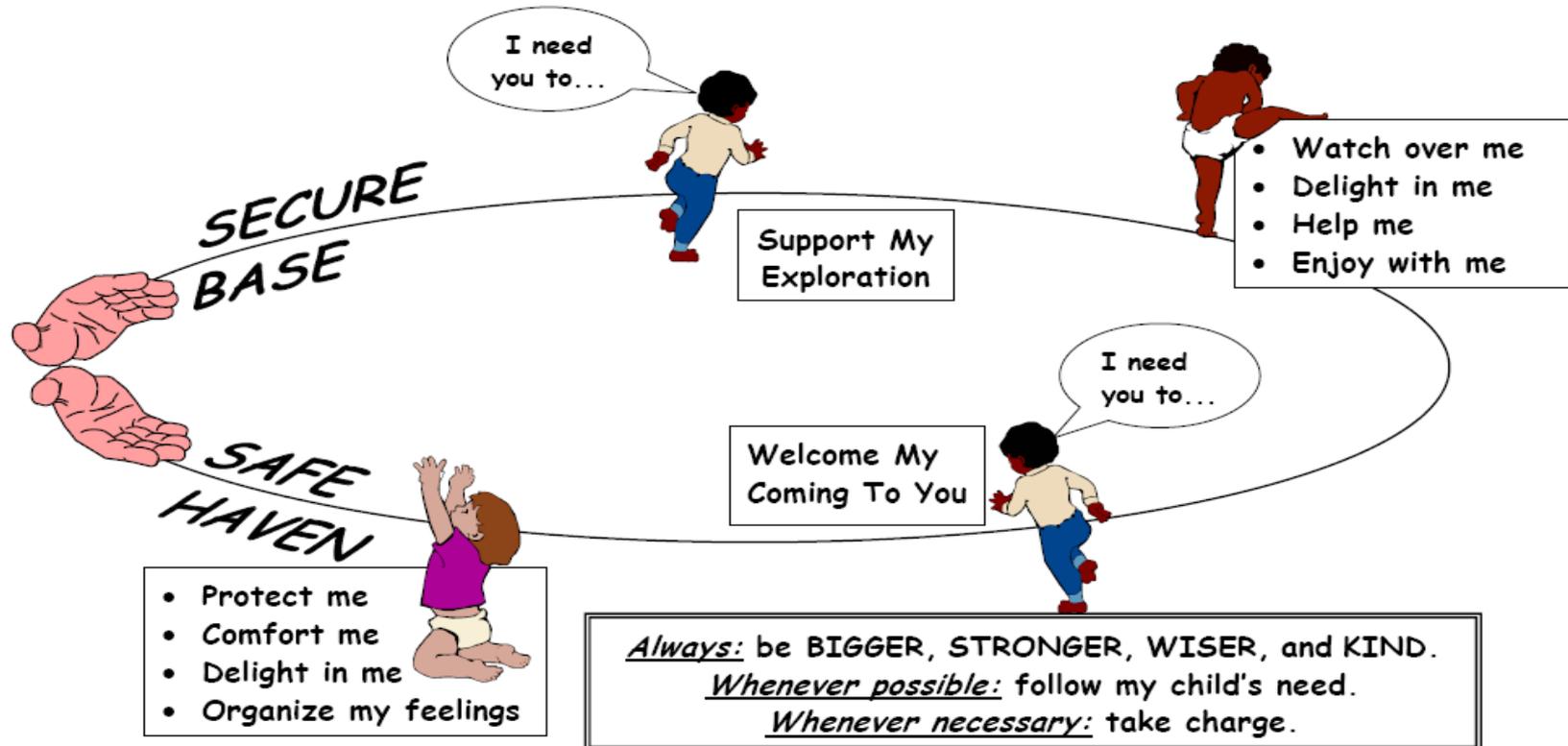
- DDP is based in attachment theory and research
- DDP is predicated on the therapist's and parents' having sufficiently well organized and secure attachment.
  - Emphasizes parenting that is available, sensitive, and responsive (from Mary Ainsworth)
  - Emphasizes the non-verbal: “The primary attachment behaviors and contingent parental responses during infancy were **NON-VERBAL**. Eye-contact, facial expressions, voice prosody, gestures and posture all generate safety for the child, help the child regulate emotions associated with traumatic memories, and help the child to develop a new experience of the trauma that facilitates its resolution.” (Becker-Weidman & Hughes, 2008).



# THE WHAT OF DDP: ATTACHMENT THEORY

## CIRCLE OF SECURITY

PARENT ATTENDING TO THE CHILD'S NEEDS



# THE WHAT OF DDP: ATTACHMENT THEORY – RUPTURE & REPAIR

- Becoming misattuned happens in all relationships, but particularly with children with complex traumatic histories.
- It is crucial to have **interactive repair** as part of treatment as so often the trauma-related material or cues are imbued with fear and shame.



- ✓ Helps the kid realize that he doesn't have to face stressful events/emotional states ALONE.
- ✓ Parent/therapist initiates it.

# THE WHAT OF DDP: INTERSUBJECTIVITY

Intersubjective experiences are the primary means whereby they infant and young child learn about themselves, others, and the world around them (Trevarthen, 2001).

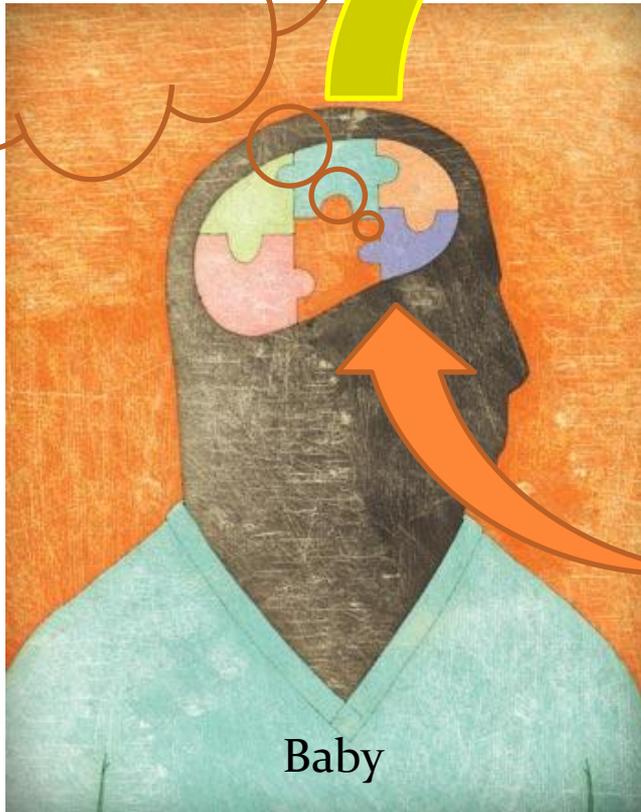
It is largely **non-verbal** and is comprised of 3 main components:

1. **Attunement** – being in synch
2. **Joint Attention** – focusing on the same object or event
3. **Shared Intention** – wanting the same things from an object or event



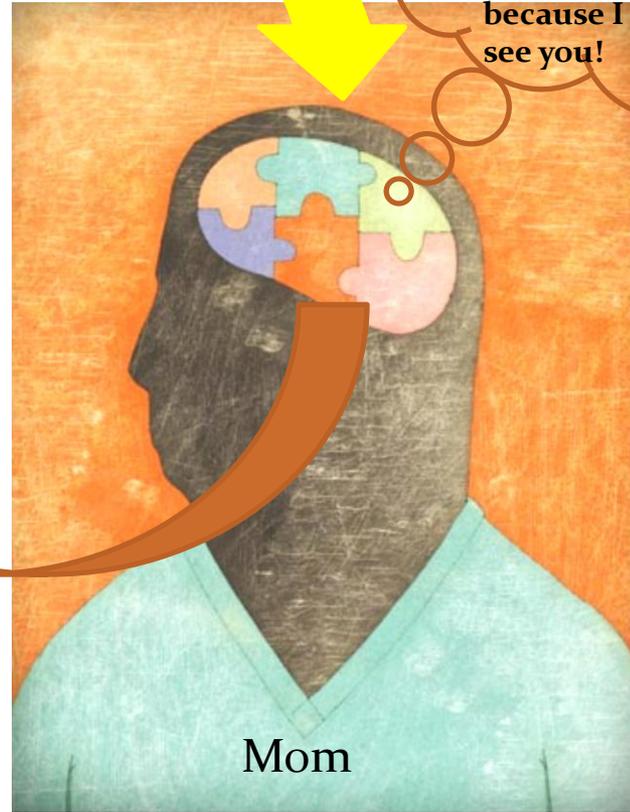
# THE WHAT OF DDP: INTERSUBJECTIVITY

I can tell by the sparkle in your eye and the tone in your voice you are **HAPPY** to see me!



I can tell by the sparkle in your eye that you know I am **HAPPY** to see you!

It makes me so **HAPPY** that you are **HAPPY** because I am **HAPPY** to see you!



# THE WHAT OF DDP: INTERSUBJECTIVITY



- When the dance of intersubjectivity goes well most of the time, children grow up with a felt sense of being able to be delighted in and loved.
- However, for children with complex relational trauma histories who have early experiences of being told/felt they are too needy, unlovable, or “bad” they tend to get anxious or dysregulated when they are told that they are loved – *there’s no non-verbal reference point.*
- “Unable to appreciate clearly who they or others are, they have problems enlisting other people as allies on their behalf. Other people are sources of terror or pleasure but are rarely fellow human beings with their own sets of needs and desires.” (van der Kolk, 2005)



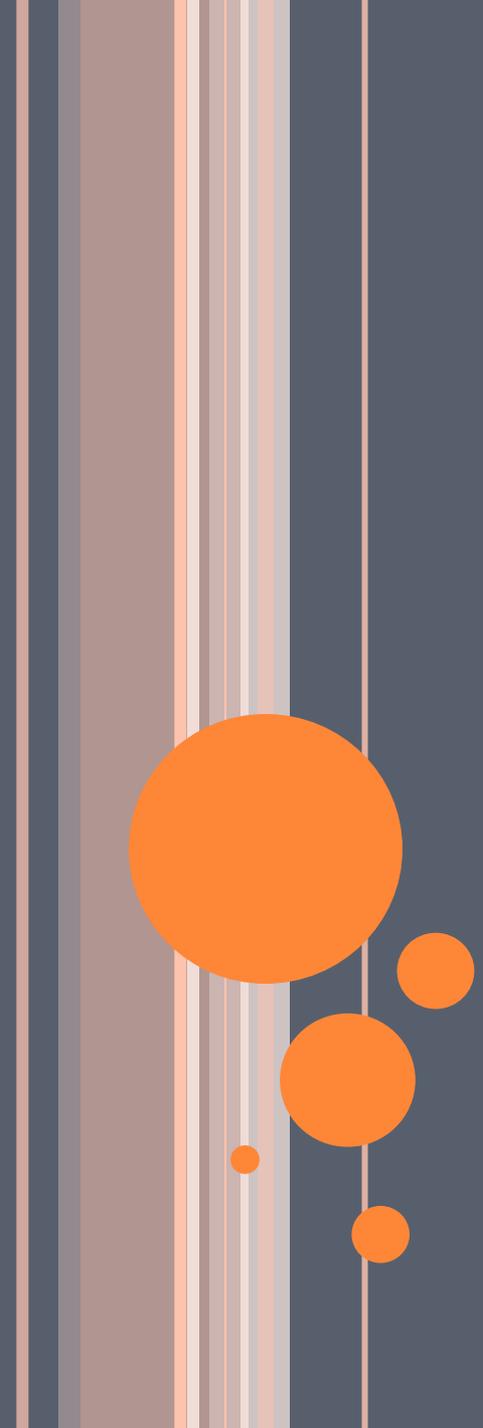
# THE WHAT OF DDP: A/R DIALOG



**a/r dialog** – Stands for affective/reflective dialog which enables both access to emotional and cognitive learning, safety and exploration through establishing a relaxed and **meandering storytelling quality** to conversation vs. a serious and rational lecture.

- Increases **reflective function** – “I know what you are thinking and feeling about me!”
- Facilitates **coherent narrative** of child’s life – “I can talk and think about my whole life without shutting down and feeling ashamed.”





# **BUILDING BLOCKS OF DYADIC DEVELOPMENTAL PSYCHOTHERAPY**

**The HOW: Attitude (P.L.A.C.E.) and Attunement**

# THE HOW OF DDP: SESSION STRUCTURE



DYADIC means parents and children  
TOGETHER!

A typical DDP session:

1. **Meet with parents**
  - a) Take their temperature see if they are able to maintain safety.
  - b) Rehearse how to understand child's behavioral or emotional issues through lens of complex relational trauma.
2. **Meet with parents and the adoptive/foster care child**
  - a) Start with a positive about the child – something specific that you or parents notice.
  - b) Move to specific difficult event of the week. Help parents and child understand event in a new way based on child's history.

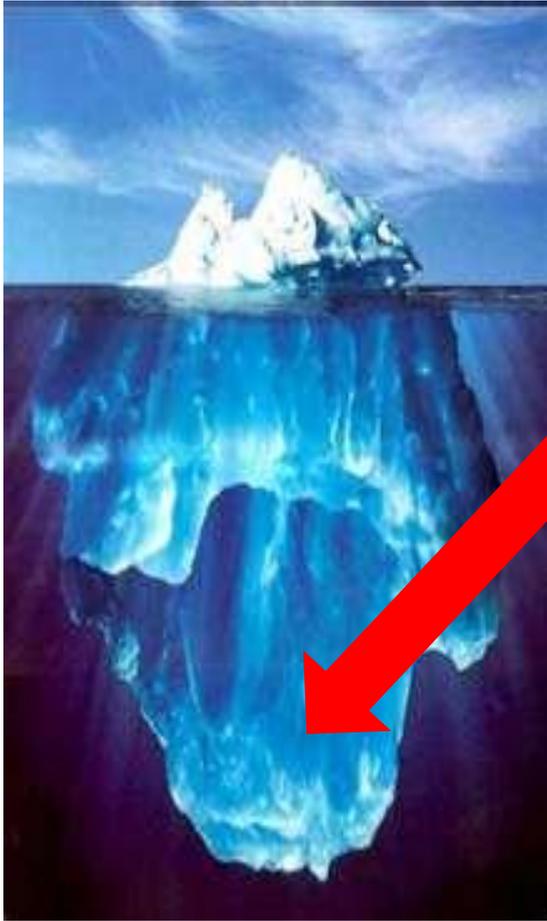


# THE HOW OF DDP: A CHANGE IN ATTITUDE: P.L.A.C.E.

- Playful
- Loving
- Accepting
- Curious
- Empathic



# THE HOW OF DDP: P.L.A.C.E. (CURIOS)



*“To become a  
**DETECTIVE.**”*

*“To not get distracted  
by the symptoms.”*

*“To experience the  
unconditional  
enjoyment of the  
child underneath  
the symptoms.”*

*- Dan Hughes, Ph.D.*

*From the Safe Place DVD (2011).*



# THE HOW OF DDP: ATTUNEMENT – RHYTHM & MOMENTUM



Vs.

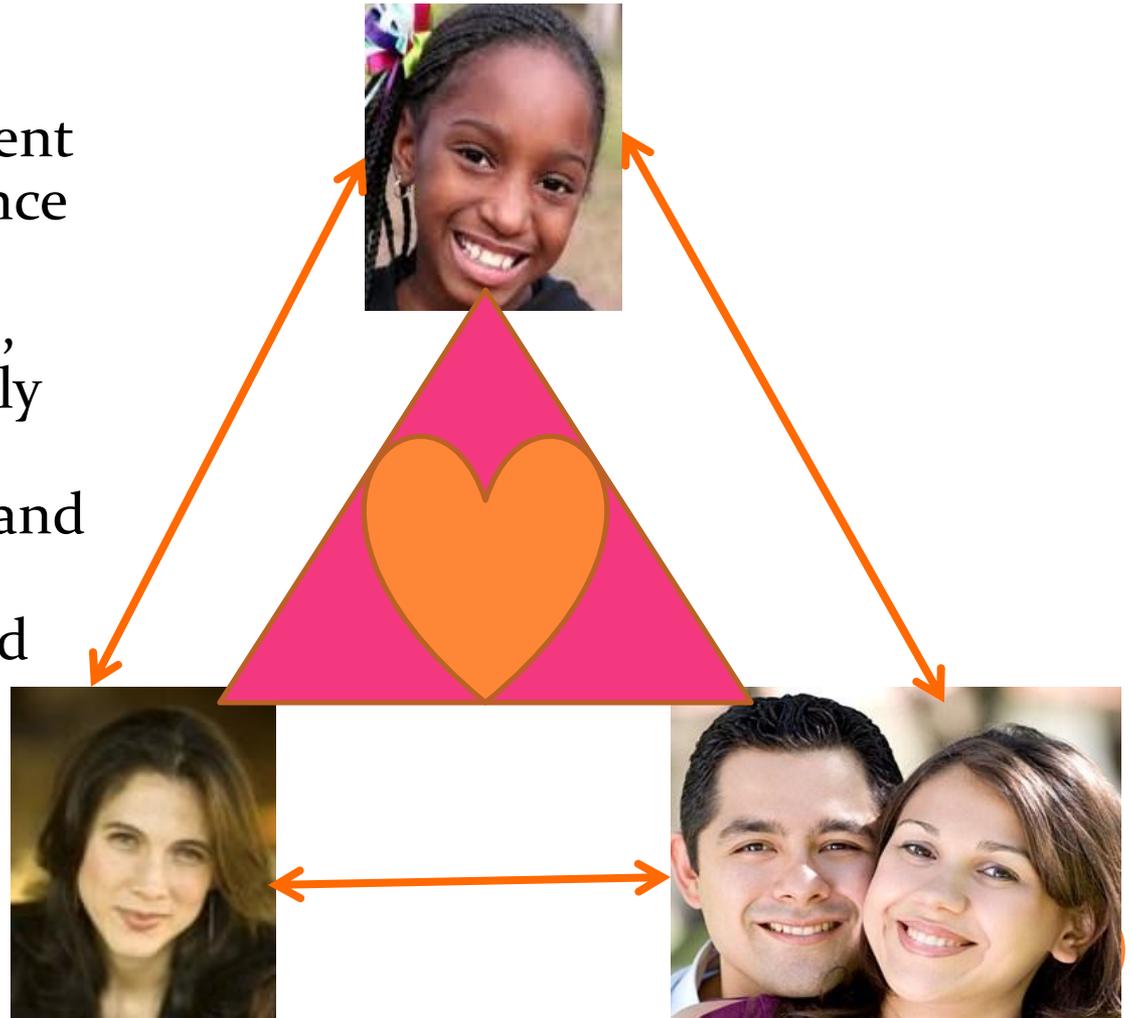


- Attunement is in part how you communicate your feelings...  
....largely through the *rhythm and intensity* of your affect  
....and by *matching* the intensity of the affect of the child



# THE HOW OF DDP: ATTUNEMENT

“Central therapeutic mechanism for treatment success, the maintenance of a contingent, collaborative, sensitive, reflective and affectively attuned relationship between the therapist and the child, between caregiver and child, and between therapist and caregiver.” (Becker-Weidman & Hughes, 2008)



# THE HOW OF DDP: ATTUNEMENT – JOINT AWARENESS & SHARED INTENTION



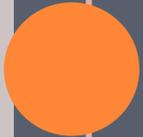
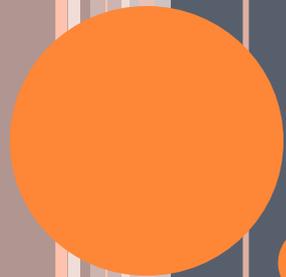
## MAKE YOURSELF INTERESTING!

Use a **STORYTELLING** voice, change the tone and emotion in your voice to bypass shame and keep the child engaged.

You want to hold the child's attention so that they can experience:

- **Joint awareness** – awareness of what the therapist/parent is aware of (e.g. good qualities about the child, loving feelings, remorse after a misunderstanding).
- **Shared intention** – experiencing the intention of parent and child both wanting to understand the child's history, of the parent wanting to connect with them and vice versa.





## DDP APPLIED

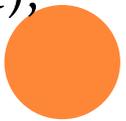
Case Example and the S's



# DDP APPLIED: CASE EXAMPLE OF R



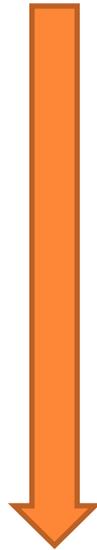
- R is a 7 y/o boy from a former Soviet Republic, who was adopted by his mother and father at age 4 y/o.
- R was removed from birth family at aged 6 months by the government due to suspected neglect related to mother's alcoholism.
- Great aunt and godmother would visit him in the orphanage periodically, but most contact with caregivers was the staff at the orphanage.
- R experienced significant neglect, physical abuse (by peers and staff at orphanage), and sexual abuse.



# DDP APPLIED: THE S'S

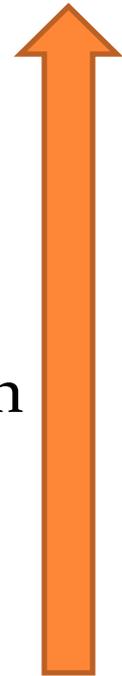
Decrease:

- Shame
- Stimulation
- Shouting
- Sarcasm
- “Shoulds”

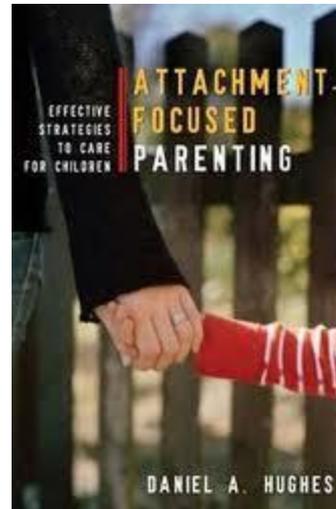
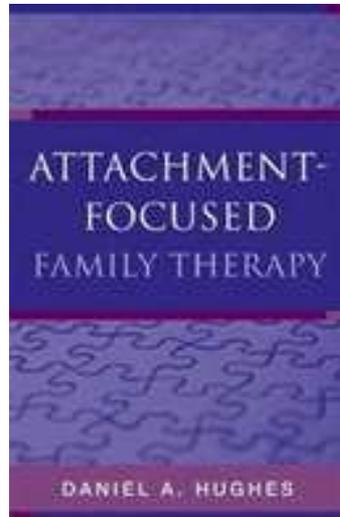
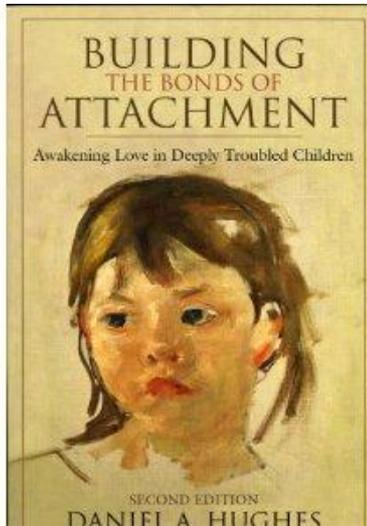


Increase:

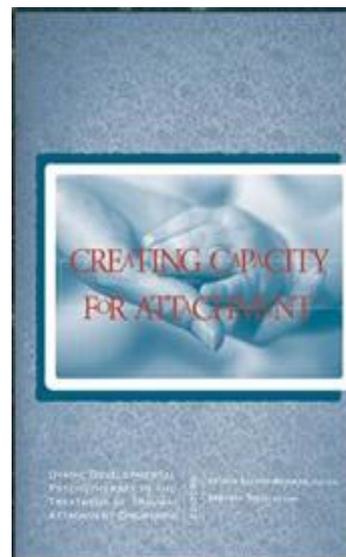
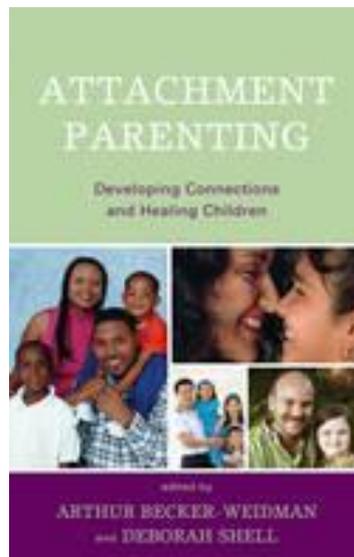
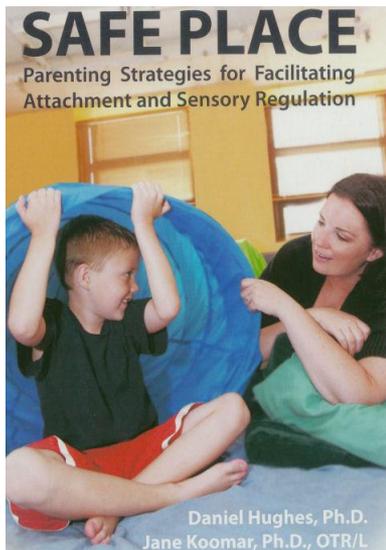
- Safety
- Success
- Structure
- Supervision
- Soothing
- Smiling



Daniel Hughes, Ph.D. [www.danielhughes.org](http://www.danielhughes.org)



Arthur Becker Weidman, Ph.D.  
[www.center4familydevelop.com](http://www.center4familydevelop.com)



## REFERENCE MATERIALS

Selected works by **Daniel Hughes, Ph.D.:**

1. Building the Bonds of Attachment
2. Attachment Focused Family Therapy
3. Attachment Focused Parenting
4. Safe Place (DVD)

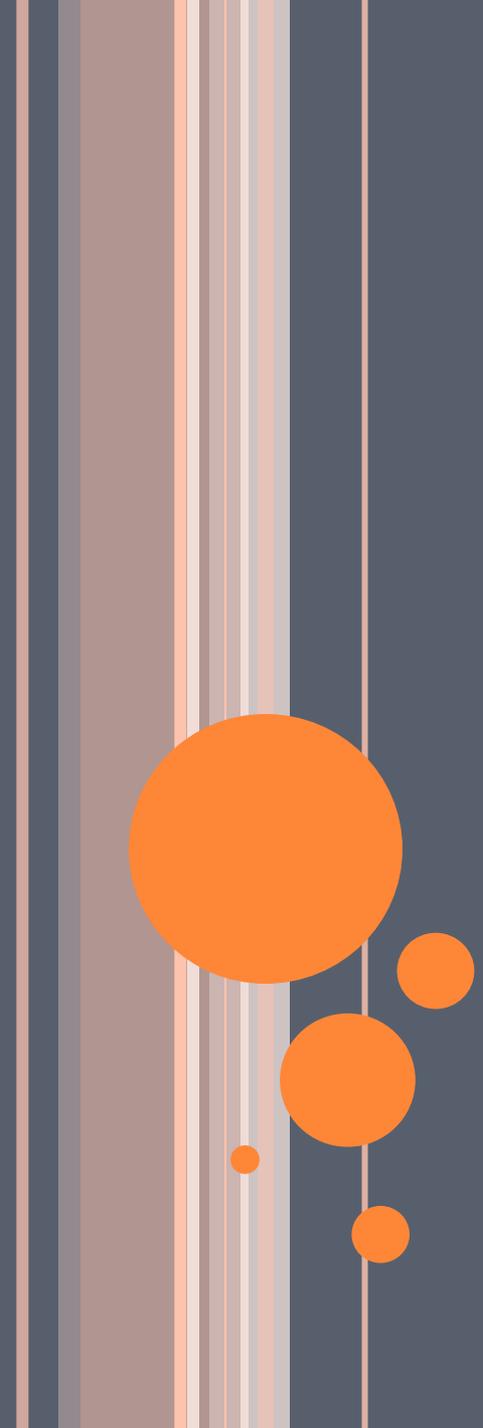
Selected works by **Arthur Becker Weidman, Ph.D.:**

1. Attachment Parenting
2. Creating Capacity for Attachment

**Dyadic Developmental Psychotherapy Institute**

[www.dyadicdevelopmentalpsychotherapy.org](http://www.dyadicdevelopmentalpsychotherapy.org)





CONTACT INFORMATION:

**COURTNEY RENNICKE, PH.D.**

**80 8<sup>TH</sup> AVENUE, SUITE 1605**

**NEW YORK, NY 10011**

**(212) 337-3565**

**INFO@COURTNEYRENNICKE.COM**

**WWW.COURTNEYRENNICKE.COM**