



Dyadic Developmental Psychotherapy (DDP): An Attachment-focused Family Treatment for Developmental Trauma

Daniel Hughes

South Portland, Maine

The impact of intrafamilial, relational trauma on the development of children is severe and pervasive, affecting all aspects of the child's functioning. The psychological treatment of children who have experienced such trauma may well have the greatest impact in facilitating their development when it adopts a relational approach incorporating central features of attachment theory while also including their caregivers when they are able to provide safety. Dyadic developmental psychotherapy (DDP), an attachment-focused family therapy, has two phases. In the first, the therapist sees the caregivers alone to ensure that they have the motivation and ability to relate with the child in ways that facilitate attachment security. This stage includes a description of the process of the treatment and the caregivers' central role in the co-regulation of emotional states, reducing the impact of the trauma on the child, assisting the child in turning to them for comfort and safety, and assisting in the development of new meanings of the trauma itself and its effect on the child's future. During the joint sessions, the therapist, utilising an intersubjective stance, actively facilitates a dialogue between therapist, child, and caregiver that incorporates the goals mentioned above and, within an open-and-engaged conversational tone, helps the child to develop a coherent autobiographical narrative that is not fragmented by terror and shame.

Keywords: developmental trauma, attachment, co-regulation of emotion, autobiographical narrative, safety in family therapy

Key Points

- 1 Childhood abuse and neglect presents pervasive developmental impairments that are very difficult to treat and resolve because it makes it difficult for the child to trust treatment providers and caregivers.
- 2 Dyadic developmental psychotherapy (DDP) is a treatment based on principles of attachment and intersubjectivity that is designed to enable traumatised children to trust their therapist and caregiver in order to turn to them for comfort and support.
- 3 The DDP therapist strives to maintain an open and engaged therapeutic stance to assist the traumatised child to experience safety and to reduce his defensive stance toward new relationships.
- 4 The therapeutic attitude of PACE (playfulness, acceptance, curiosity, empathy) facilitates the open and engaged, intersubjective, therapeutic stance.
- 5 DDP facilitates the development of healing and integrative conversations with children that explore all aspects of their past and current lives.
- 6 DDP facilitates safety through the co-regulation of affect and then addresses events characterised by fear and shame through the co-creation of new meanings of those events.
- 7 DDP develops the capacity of abused and neglected children to experience comfort and joy with their caregivers.

Jenny had just turned three when her father first hit her on the side of her head, sending her flying to the floor in an explosion of shock, terror, and pain. That was immediately followed by her mother screaming at her father and her father hitting her mother. After

Address for correspondence: dhughes202@gmail.com

that her mother hit her too, more often than her father did, but not so hard. Just a slap here and there. What hurt Jenny the most though was her mother's eyes. When she looked into her eyes when her mother was angry with her she saw hate, contempt, and sometimes even wishes that she were dead. So, she stopped looking. She had long since stopped asking to play with her parents. Or wanting to be held. She didn't talk with her parents much. She mostly was content to play by herself with her few toys. She could control what happened then and she was hurt less and frightened less.

Jenny found a way to survive by relying on herself to keep busy and to handle anything that might be upsetting. She learned not to have big feelings or thoughts that might create big feelings of sadness, loneliness, fear. Sometimes throwing and breaking her things also helped to make those hard feelings go away. When Jenny was four she was in a preschool program that included day care, from nine to five. It was a confusing and scary place with so many adults and kids. But she wasn't hit there and there was good food. She liked the toys and the other kids left her alone because she would knock them over if they tried to play with something that she wanted.

When Jenny was almost five she was placed in a foster home and that was confusing and scary too. A teacher had seen a bruise on her cheek and she told her that her father had hit her because she had made a noise that woke him up. Then she showed her other bruises and the teacher called Sue who was a social worker who put kids in homes where they were not hit. And she liked the food in her new home. Angie and Kevin were nice enough, though she wished that they left her alone to play more. They wanted to talk with her and do things with her. Jenny figured that if she spent a lot of time with them she'd only get into trouble and they might start hitting her. She also would get scared and confused when they gave her a hug or invited her to sit in their lap. After a while she realised that when she did do something wrong they did not hit her. She even got angry with them and they still didn't hit her. So, she just started getting more and more angry when they said no to her or were mean to her in other ways too. If they wanted her to be happy, why didn't they let her do what she wanted?!

Jenny's emotions started coming out more – her anger mostly. She was scared at first when Angie and Kevin started getting angry back. But then she realised that they still did not hit her, so she did not mind their anger. Actually, it made her feel comfortable, she was used to parents being angry with her. It seemed to fit what she expected to happen and wasn't so scary as hugs. In fact, she learned that if she wanted them to stop trying to be nice to her or hug her, all she had to do was make them angry. If she could just get them to let her do what she wanted to do, everything would be fine.

Jenny is one unique child who is like so many other children who have experienced what many are now referring to as developmental trauma – the trauma occurred within her own family and within her relationships with her parents (van der Kolk, 2005). Such trauma is especially hard to resolve because it destroys the child's sense of safety that is crucial for her development (Cook et al., 2005). She is likely to develop domains of impairment affecting her attachments, biological processes, affect regulation, cognition, behaviour, and sense of self. Such trauma is hard to resolve because of the pervasive sense of shame and fear it creates which is likely to activate states of dissociation and/or rage. Resolution is made difficult because it destroys trust.

Just stopping the traumatic events in Jenny's life will not be sufficient for her to feel consistently safe and proceed with her development. Her developmental age is likely to be less, and she is at risk of failing the routine expectations that are placed

on her and other children her chronological age. She cannot allow herself to be sad and to seek comfort. She cannot allow herself to feel happy and to seek joy. She mistrusts adults, especially parents, so she has to rely on herself for her basic needs, and she is likely to try to reduce her social and emotional needs. Thus, the trauma lives on within her. It is truly developmental. Her parents may not be able to hurt her anymore, they may even have no contact with her, but they continue to be hurting her through what they have done to her mind and heart. This model of treatment and care – dyadic developmental psychotherapy (DDP) – has the goal of reducing the ongoing impact that her parents still have on her, while opening her mind and heart to the more positive experiences she is having with her new parents or carers, as well as her teachers and her therapist.

DDP is a model of therapy and care based on the theories and research of attachment, intersubjectivity, interpersonal neurobiology, and trauma. Its premise is based on the child's need for psychological safety with positive intersubjective experiences if she is to reduce the impact of past relational trauma and increase the impact of her relationships with the important people in her current life. Its goal is to utilise the therapeutic relationship to enable the child to experience a new relationship, one that is intersubjective, and enables her to have a new experience of herself and those caring for her.

The external events of Jenny's life are easily divided into two parts, the first in which she experienced developmental trauma and developed the areas of impairment in her functioning. The second part involves her life in foster care and the absence of traumatic events. However, the two parts are joined by the fragmented sense of self with significant challenges to her emotional, reflective, and relational functioning. In order to facilitate her psychological integration, she needs relational assistance in reducing the shame and terror of the first part of her life while increasing her ability to differentiate her new carers from her parents and enter new intersubjective experiences. For the sake of her sense of safety these explorations in therapy are likely to begin with her current life in foster care, and then in a reciprocal manner moving back and forth between the past and present. As the attachment with her foster carers develops she is more able to explore and resolve the past traumas. The support that her carers are giving her to explore the past traumas enables Jenny to develop a secure attachment with them.

The Foundations of DDP

Attachment

Attachment is now considered to be our most comprehensive and – with over 30,000 studies – best researched theory of human development (Cassidy & Shaver, 2016). Securely attached children and adults are likely to be able to identify, regulate, and express their affective lives (Schore & Schore, 2014). They are likely to have good reflective skills (Fonagy, Luyten, Allison, & Campbell, 2016) and to be able to have empathy for the inner lives of others while having an integrated sense of self (Thompson, 2016). They are likely to be both cooperative and assertive and to experience satisfaction and joy in relationships with others (Sroufe, Egeland, Carlson, & Collins, 2005). It is no wonder that individuals who are securely attached have traits characteristic of mental health and those who have a disorganised attachment are at risk for the development of psychopathology (DeKlyen & Greenberg, 2016). These skills

persist throughout the whole life cycle, with attachment themes again becoming prominent among the elderly (Cassidy & Shaver, 2016).

Attachment's function is to create safety through relationships with a few key persons in our lives (Cassidy, 2016). Children turn to their parents for safety. Once the infant feels safe, the infant is then safe to explore the world. Children then turn to parents for their guide to learn who they are, who others are – especially the parents – and what is the bigger world in the family, and then the neighbourhood, and then beyond. When these acts of exploration lead to any threats to safety, then the parent, as the attachment figure, becomes once again desired. Adults of all ages also tend to seek their attachment figure – partner, best friend, parent, sibling – when they experience a threat to their safety. In DDP the experience of safety through attachment, especially for children who have experienced trauma within prior attachment relationships, is at the core of the therapeutic value that it provides for these children.

Intersubjectivity

Once the child is safe to explore, the primary way that they begin to learn about themselves, others, and the world is through intersubjective experiences. The child discovers who she is through her experiences that her parents have of her that they communicate to her. If they experience and communicate delight, interest, and love, then she experiences herself as being delightful, interesting, and lovable. On the other hand, if the parents communicate boredom, anger, and indifference, then the child is likely to experience herself as not interesting, bad, and unlovable. These early intersubjective experiences are communicated nonverbally through facial expressions, eye contact, voice prosody (rhythms, intensity, pitch, pauses), gestures, and posture (Trevarthen, 2001, 2016).

For these experiences to be intersubjective they need to have three components (Stern, 1985). First, they need to be synchronised affectively – attunement – which is crucial for the child's developing ability to regulate her emotional states, initially, through having their affective expressions co-regulated with their parents. Second, they need to involve the joint awareness of – and attention being given to – the same object or event. The parent and child both have to be giving their attention, for example, to the dog, if the parent's experience of the dog is able to influence the child's experience of the dog. Third, the intention that the parent and child need in engaging in the joint experience needs to be complimentary. For it to be intersubjective, if the parent wants to teach, the child needs to want to learn. If the parent wants to understand, the child needs to want to be understood.

Intersubjective experience is prominent in DDP. The therapist relates with the child nonverbally with facial expressions, voice prosody, and gestures, becoming synchronised with the expressions of the child. When a child is expressing her angry emotion with intensity in her voice and facial expressions and the therapist matches those expressions nonverbally without feeling angry herself, the child is likely to remain regulated. ('You REALLY were upset that you couldn't visit your friend!') The therapist is often able to engage a child in exploring a stressful event through using a rhythmic, 'story-telling' voice. The therapist is often able to evoke a complimentary intention from the child when she simply wants to get to know the child's experience without judging it. These intersubjective experiences together often enable the therapist to engage in an ongoing dialogue with the child during the therapy session.

Interpersonal neurobiology

Findings from interpersonal neurobiology are also congruent with the therapeutic goals and activities of PACE (playfulness, acceptance, curiosity, empathy). The writings of Alan Schore (2001) and Daniel Siegel (2012) make clear how the overwhelming findings from research on the structure and functioning of the brain and nervous system indicate that we function best neurobiologically when we are engaged in relationships with others with whom we are safe. With safety we become engaged with others in cooperative activities of mutual interest and benefit. Within connections with others, our brains are best able to become integrated bottom to top, right to left, back to front (Solomon & Siegel, 2017). We are then able to integrate our thinking, feelings, and bodily states, our memories and our hopes and dreams. We can balance our concerns for both self and other and find ways to hold competing ideas and mixed emotions.

The polyvagal theory of Stephen Porges is consistent with this understanding of our nervous system (Porges, 2011). According to Dr Porges, when we are safe, our nervous system activates our social engagement system, that enables us to best develop our skills as social mammals. We become good at communicating with others nonverbally, which is the core of social-emotional communications. This involves a state that Porges calls being open and engaged with others which is the best way to influence and be receptive to the influence of others. He contrasts this open and engaged state which exists when we are safe, with the defensive state which we enter when we are feeling threatened – either physically or psychologically. When two people are relating they tend to both be open and engaged or both defensive. If one person who is open and engaged, when relating to a defensive person, is able to inhibit themselves becoming defensive, the defensive person is likely to become open and engaged. Intersubjective experiences develop in a way that is best for the child when both parent and child are open and engaged. Staying open and engaged and facilitating that state in the child is a primary therapeutic endeavour.

For neurobiological reasons it is difficult remaining open and engaged with a child for weeks, months, and years when that child is habitually defensive and nonresponsive to their caregivers' care. When parents who have been consistently rejected start to become defensive themselves during most of their interactions with their children they enter a psychological state which we now call 'blocked care' (Baylin & Hughes, 2016; Hughes & Baylin, 2012). Blocked care refers to the caregiver 'doing their job' but without having the heart needed to be able to impact their child. A parent experiencing blocked care will be unlikely to influence the further development of a child experiencing blocked trust.

Dyadic Developmental Psychotherapy

DDP has developed over the past 25 years, beginning when its founder was unsuccessful in his therapeutic efforts with abused and neglected children and their caregivers while using the traditional therapeutic interventions considered to be best practice at the time (Hughes, Golding, & Hudson, 2018). Originally developed for children experiencing developmental trauma, DDP gradually became used as an attachment-focused therapy for children, in a family setting, when they had not experienced developmental trauma (Hughes, 2011).

The Structure of the DDP Sessions

The DDP therapist meets with the carers alone (or with the primary carer if the other is not able to attend) as well as the child and carers together. She needs to establish a good working alliance with the carers if they are to experience safety within the session and then help the therapist to develop safety for the child in the session. As a result, she will both see the carers before meeting with the child as well as periodically during the course of therapy to review progress and interventions and to repair their alliance when necessary.

When meeting with the parents alone, the DDP therapist has the following themes that are addressed before having joint sessions:

- The carers' own attachment histories have no unresolved traumas. There also are no relationship patterns that would make it difficult for them to raise a foster child in a manner that she needs to resolve her developmental trauma.
- The carers are committed to continuing to care for the child and they are not experiencing blocked care due to the difficulties in providing her care.
- The carers are receptive to trying other ways of caring for their foster child. These ways greatly utilise the attitude of PACE.
- The carers are not habitually defensive throughout the interview including when the therapist suggests other ways of caring for the child. They also are committed to resolving differences and repairing the relationship with the therapist when needed.

The Interventions of DDP

Playfulness, acceptance, curiosity, empathy

Throughout the treatment sessions the DDP therapist maintains the attitude of PACE in order to best facilitate safety and learning. She also facilitates the carers having the same attitude of PACE at home. *Playfulness* conveys a sense of optimism and hope for the family's journey forward together. It provides context so that the problems are not experienced in isolation from the routines and special events of daily living. At times it conveys lightness and laughter, looking for ways to experience and enhance the positive qualities of their relationships. This enables the child to experience a bit of happiness and companionship which she is going to need if she is to move beyond her isolation, fears, and shame. *Acceptance* represents the process of not judging the child's inner life of thoughts, feelings, and wishes, while limiting evaluations of the child to her behaviours. This helps the child know that she is safe to express her inner life. She will not be scolded for being angry with her carers or not liking her carers. She will only be scolded if she demonstrates her experience of them with certain behaviours (hitting, swearing). *Curiosity* is also nonjudgmental. It enables the therapist to begin to know the inner life of the child and in the process, help the child to develop the reflective functioning needed to become aware of and be able to express her inner life. Curiosity is not intrusive but rather represents a desire to understand how she experiences her life. The therapist is fascinated with who she is. What is the story that the child has created to manage the hard parts of her life and make sense of them? How has she found ways to feel safe? What do parents, peers, and others mean to her? *Empathy* is the experience of the child's struggles with the events of her life and her developing sense of self. This is then expressed to the child so that she

experiences the other's experience along with her own. She is not alone in her distress and she has the experience that the therapist understands her. With PACE, the child may, for the first time, experience someone who truly wants to understand her and her life, with no evaluation of it being right or wrong. Her sense of self, her identity, how she has made sense of things is not being questioned. When others challenge her, they are questioning only her behaviour, not her person. Her carers do not add to the shame she experiences for who she is.

Affective-reflective dialogue

Affective-reflective (A-R) dialogue is the primary therapeutic activity. In essence it refers to the process of having a therapeutic conversation with a child who was traumatised within an important relationship. This activity is simple though often difficult to initiate and maintain with children who mistrust conversations and often have little experience becoming engaged in one. This conversation is affective, evoking a range of emotions that are associated with themes and events in the child's life. It is also reflective: wondering about those themes and events to make sense of them and understand how they might relate to other aspects of the child's life.

The therapist takes an active stance in maintaining the rhythm and momentum of the conversation. She ensures that it does not move into a lecture or an exercise in problem-solving. It is a descriptive process of exploration not an evaluative one. When the child struggles with finding the words to respond to the therapist's curiosity, the therapist guesses what the child might think, feel, or wish for. These guesses are always tentative and when the child says that the guess is wrong, or she does not know, her statement is always accepted. Often these guesses help the child to discover something different that she did think or feel. The child is gradually learning how to reflect with an adult who is reflecting with her. She is also learning how to regulate her emotional states with an adult who is co-regulating these states affectively (affect defined as the bodily expression of an emotion).

At times the therapist facilitates the conversation by speaking for the child and speaking about her. In speaking for a child, the therapist might guess what her nonverbal expressions might mean, or she might guess what she was thinking or feeling when something happened. With the child's permission, the therapist might also speak for the child to the parent about the child's experiences, often involving the parent, which she had just been exploring with the therapist. These activities of speaking for a child often help them to be aware of and to safely express their emotions, especially those associated with vulnerability. Speaking about a child to a parent (or even by the therapist thinking out loud or talking to herself) helps the child to listen without defensiveness and gradually facilitates the development of reflective functioning.

Conversations are about the child's entire life, not simply about the problems or traumas. The therapist often establishes the momentum in the session by directing the conversation to safe, interesting, light topics. Then, without changing the rhythm of the dialogue or tone of voice, the therapist introduces the traumatic or shame-related theme. Often, within that context, the child can continue the dialogue around the much more stressful theme.

Co-regulation of affect and co-creation of meaning

The DDP therapist always has two goals which are interwoven. These are creating safety through the co-regulation of the child's affective states and developing new

stories of her life through the co-creation of new meanings to the events of her life. Safety always precedes exploration and when exploration jeopardises safety, it is discontinued until safety is re-established. Along with co-regulating the child's affective states, the therapist is also ensuring safety through creating a balance between nondirective and directive interventions and engaging in interactive repair whenever needed. The therapist facilitates the co-creation of new meanings to events of shame, rage, and terror through her active stance of both creating and maintaining the momentum of the A-R dialogue as well as helping the child to find the words for the vulnerable emotions and thoughts that lie under her struggles. The story being co-created is coherent and comprehensive, without the gaps and distortions characteristic of the previous story that was embedded in fear and shame.

DDP with Jenny

Rather than present the structure and interventions of DDP in greater detail, the focus will rather present the story of Jenny and her carers, Angie and Kevin, while they were engaged with DDP.

First, the DDP therapist, Tina, makes sure that Angie and Kevin feel safe in the session so they and the therapist can work together to help Jenny feel safe. Tina meets Angie and Kevin for a number of sessions while developing an alliance with them, explains their role in the therapy sessions, and ensures they have a commitment to providing the care being recommended. However, when Angie and Kevin were told by Tina that she wanted to meet with them first before seeing Jenny, they were anxious and somewhat defensive. Were they being blamed? Tina's relaxed and engaging greeting reassured them at first, but when she started to ask about Jenny's behaviours and their responses they became worried again. Tina related through PACE and she focused her curiosity on how they were responding to her questions. Her nonjudgmental acceptance helped them to become open and engaged again so she continued with developing their story of the impact on them of Jenny living with them. How did it affect them that Jenny had become increasingly defiant and showed little interest in their affection or sharing her thoughts and feelings with them? Tina wondered about whether or not they were experiencing blocked care? As they remained non-defensive she then asked if aspects of their own lives as children were in any way awakened by Jenny's behaviours, giving them examples of what she meant. At every step, if Angie or Kevin became defensive, Tina stopped exploring their story further until first she repaired their relationship with her and helped them to become open and engaged (and therefore trusting). Tina held the same attitude involving PACE that she would later have with Jenny. Once Tina was confident that the carers would be able to actively participate in the therapy in a manner that would be helpful to Jenny, she informed the carers of the nature of DDP and the likely interactions that would be facilitated in the sessions.

When Jenny joined the sessions with her carers (most sessions Kevin was unable to attend, though he was always informed about the session by Angie, with Jenny present, when they got home), she was anxious as well as resistant, withdrawn, inattentive, and hyperactive. Given her history and her functioning in her foster home, this was not a surprise to Tina. As usual, her first task was to facilitate conversations with Jenny. She began with the simple goal to 'connect and chat.' The topics were light, interesting, humorous, immediate. Even those were difficult for Jenny, so Tina

took the lead. She brought up topics and maintained the dialogue with expressions of strong interest and enthusiasm. She wondered about Jenny's experiences. She wondered about Jenny's experience and when she was not forthcoming, she made guesses, in a light, relaxed manner. Tina's nonverbal expressions were central in conveying her emotions and thoughts. These involved her voice prosody, facial expressions, gestures, and posture. With her expressions, she was open and engaged with Jenny. She was hoping that they would enter into a joint, synchronised rhythm of expressions, much like the attuned interactions between parent and infant. These synchronised non-verbal expressions would be central in facilitating Jenny's safe engagement with Tina in the conversation they were developing. These are small stories being formed. They involved the colourful dots and patterns on Jenny's shoes, with humorous ideas about what they might mean. Tina wondered if there were shoes like that in her size and if so, if her patterns and colours would be different. She brought up the rain storm that Jenny got caught in on the way into the office. She wondered if Jenny had any frogs in her pocket, if her hair was turning colours, if she was growing gills.

A bit of playfulness, and Jenny slowly responded, helping the conversation to get started. Tina then used the momentum of the conversation to glide into other themes that were more difficult. Her mind was open to connections to any aspect of Jenny's history. She took the colours on her shoes and wondered about the emotion that was conveyed by each colour. Maybe grey suggested feeling tired and Tina wondered when Jenny was tired, how she slept, what she thought about in bed, if she had nightmares, other dreams, what did it feel like waking up with Angie and Kevin, what is the first thing she liked to do when she woke up, and what she most liked doing when she went to bed? The questions were seemingly endless, one loosely connected to the prior one, always lightly introduced, always accepting Jenny if she did not want to talk about any question.

Thus, the conversation continued, it meandered, it developed energy and strength, it became quiet and gentle. It moved from the present to last week to two years ago, to two weeks ago, to next weekend. Always accepting, always wondering what this and that meant. The strong background messages were that Jenny is accepted, she is interesting, she is worthy of care and value and joy and comfort.

Over the first several sessions, Jenny increasingly joined the conversation, expressed her inner life a bit, and then withdrew to listen. And see if she had been trapped into something, if she was being criticised and evaluated. But she never was. Her words were accepted as her silence was accepted. And she was discovering that when her words were accepted it felt nice, sort of like she might be special, that she mattered to the people in the conversation with her – that she had something to offer. She had a bit of a conversation and then she would pull back. And the next time she stayed a little longer. At some point Tina noticed her hesitations – with acceptance – and wondered about them. She expressed some sadness that Jenny sometimes did not think that anyone was interested in her, cared about her. As Jenny was still listening, Tina led it a bit further. She turned to Angie and suggested that maybe when Jenny lived with her parents they did not talk with her much, they did not listen to her much. She might have thought that she had nothing interesting to say, that there was nothing special about what she thought or felt or who she was. This tentative connection was presented with a sense of shock that Jenny might have experienced that, followed by empathy for how hard it would have been if she did. These thoughts were

presented to Angie, not Jenny, since this would make it easier for Jenny to listen, knowing that she did not have to respond.

As Jenny was still quietly engaged, Tina gently directed a question to her: 'I was thinking about all the hard times that you had when you were living with your mum and dad. Did you ever wonder why it was all happening? If there was anything that you could do so that they'd treat you better?' Jenny got distracted by something and Tina accepted that, quickly commenting that maybe they'd had enough of talking about this stuff for the day. But Jenny did not move, she just sat quietly with a look of sadness on her face. Angie gave her hand a quick squeeze. Tina then quietly said, 'Jenny I'm glad that you let us talk about this for a bit because you've probably thought about that stuff at times, and it's harder to think about that kind of stuff alone. Now you have Angie and I to try to understand it with you. Maybe, we all need to take a rest now. Let's get some hot chocolate and maybe read a book before we stop for the day.'

Slowly, gently, persistently, Tina, Jenny, and Angie placed their minds and hearts on Jenny's life. From this process, Jenny developed a narrative that had less fear and shame and was coherent, consistent, and comprehensive. In the sessions ahead, Tina helped Jenny to:

- remember and discuss the traumatic events from her past with less fear and shame;
- understand how her traumatic experiences with her parents made it hard to trust Angie and to accept her discipline;
- turn to Angie more for comfort and support;
- begin to understand and then reduce her sense of shame;
- begin to develop experiences of pride and joy, first with Angie and Kevin and then by herself, and also with peers.

Conversations that are experiential and which develop coherent life stories are central in DDP. They were the way forward for Jenny to resolve her experience of developmental trauma and to develop a secure attachment with Angie and Kevin. As she learned to regulate her affective states through their being co-regulated with Tina and Angie, she no longer had to try to regulate them through attempting to control and being defensive. As she became safe to begin to explore who she was and develop new meanings of her traumatic past, she did not fall back into the old meanings covered with terror, shame, and rage. She was able to co-create new meanings with Tina and Angie and the inter-subjective experiences being generated by PACE and the A-R dialogue.

References

- Baylin, J., & Hughes, D.A. (2016) *The Neurobiology of Attachment-focused Therapy: Enhancing Connection & Trust in the Treatment of Children & Adolescents* (Norton Series on Interpersonal Neurobiology). New York: Norton.
- Cassidy, J. (2016). The nature of the child's ties, in J. Cassidy & P.R. Shaver (Eds.), *Handbook of Attachment* (3rd ed.) (pp. 3–24). New York: Guilford.
- Cassidy, J., & Shaver, P.R. (2016). *Handbook of Attachment* (3rd ed.). New York: Guilford.
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagen, R., Liataud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35(5), 390–398. Retrieved from <https://doi.org/10.3928/00485713-20050501-05>

- DeKlyen, M., & Greenberg, M.T. (2016). Attachment and psychopathology in childhood, in J. Cassidy & P.R. Shaver (Eds.), *Handbook of Attachment* (3rd ed.) (pp. 639–666). New York: Guilford.
- Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2016). Reconciling psychoanalytic ideas with attachment theory, in J. Cassidy & P.R. Shaver (Eds.), *Handbook of Attachment* (3rd ed.) (pp. 780–804). New York: Guilford.
- Hughes, D.A. (2011). *Attachment Focused Family Therapy: The Workbook*. New York: Norton.
- Hughes, D., & Baylin, J. (2012). *Brain-based Parenting: The Neuroscience of Caregiving for Healthy Attachment*. New York: W.W. Norton.
- Hughes, D.A., Golding, K.S., & Hudson, J. (2018). *Dyadic Developmental Psychotherapy: Healing Trauma with Attachment-focused Interventions for Children and Their Families*. New York: Norton.
- Porges, S. (2011). *The Polyvagal Theory: Neurophysiological Foundations of Emotions Attachment, Communication, and Self-Regulation*. New York: Norton.
- Schore, A.N. (2001). Effects of a secure attachment on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, 22(1–2), 7–66. Retrieved from [https://doi.org/10.1002/1097-0355\(200101/04\)22:1<7:AID-IMHJ2>3.0.CO;2-N](https://doi.org/10.1002/1097-0355(200101/04)22:1<7:AID-IMHJ2>3.0.CO;2-N)
- Schore, J., & Schore, A.N. (2014). Regulation theory and affect regulation psychotherapy: A clinical primer. *Smith College Studies in Social Work*, 84(2–3), 178–195. Retrieved from <https://doi.org/10.1080/00377317.2014.923719>
- Siegel, D. (2012). *The Developing Mind* (2nd ed.). New York: Norton.
- Solomon, M., & Siegel, D.J. (Eds.) (2017). *How People Change: Relationships and Neuroplasticity in Psychotherapy*. New York: Norton.
- Sroufe, L.A., Egeland, B., Carlson, E., & Collins, W.A. (2005). *The Development of the Person*. New York: Guilford.
- Stern, D. (1985). *The Interpersonal World of the Infant*. New York: Basic Books.
- Thompson, R.A. (2016). Early attachment and later development: Reframing the questions, in J. Cassidy & P.R. Shaver (Eds.), *Handbook of Attachment* (3rd ed.) (pp. 330–348). New York: Guilford.
- Trevarthen, C. (2001). Intrinsic motives for companionship in understanding: Their origin, development, and significance for infant mental health. *Infant Mental Health Journal*, 22(1–2), 95–131. Retrieved from [https://doi.org/10.1002/1097-0355\(200101/04\)22:1<95:AID-IMHJ4>3.0.CO;2-6](https://doi.org/10.1002/1097-0355(200101/04)22:1<95:AID-IMHJ4>3.0.CO;2-6)
- Trevarthen, C. (2016). From the intrinsic motive pulse of infant activity to the life time of cultural meanings, in B. Molder, V. Aristila, & P. Ohrstrom (Eds.), *Philosophy and Psychology of Time* (pp. 225–266). New York, London: Springer.
- van der Kolk, B. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5), 401. Retrieved from <https://doi.org/10.3928/00485713-20050501-06>