Practice Models for Enhancing Parent-Child Attachment

1. Introduction

1.1 Introduction

Welcome back to the National Adoption Competency Mental Health Training for Mental Health Professionals. This lesson is: Practice Models for Enhancing Parent-Child Attachment.

This lesson focuses on additional attachment based interventions with a strong evidence base.

1.2 Section 1: Lesson Objectives

At the end of this lesson, you will be able to:

- Identify and describe strategies and therapeutic tools for helping families understand and honor their children's and youth's previous attachments and unique story, and
- Integrate therapeutic parenting strategies that enhance children's and youth's attachment

1.3 Attachment-Based Therapies

In the previous lesson, we explored three attachment-based therapies and briefly reviewed five other interventions in the handout. We will continue by introducing two additional evidence-informed attachment therapies: Dyadic Developmental Psychotherapy and Theraplay.

2. Dyadic Developmental Psychotherapy

2.1 Dyadic Developmental Psychotherapy

Let's start with Dyadic Developmental Psychotherapy (DDP).

2.2 The Focus of DDP

Dyadic Developmental Psychotherapy (DDP) is a treatment approach to trauma and loss, and/or other dysregulating experiences, developed by Dr. Dan Hughes. It is primarily designed to address the needs of children and youth ages 2 to 21 who have trauma and attachment disruption histories.

DDP seeks to increase parent-child attachment while helping children to make sense of, and accommodate, their painful histories and related feelings and behaviors.

The key concepts of DDP include:

- Creating a safe setting in which the child or youth can begin to explore, resolve, and integrate a wide range of memories, emotions, and current experiences that are frightening, shameful, avoided, or denied
- Ensuring that this exploration occurs within an intersubjective context, characterized by verbal and nonverbal attunement, and reflective dialogue
- The youth's creation of a coherent life story or narrative, which is crucial for attachment security, and is a strong protective factor against psychopathology

Within this context of safety and attunement, the therapist carefully and tenderly explores with the child or youth and parent a wide range of their difficult memories and current experiences. In this way, the child or youth is supported in identifying and processing negative feelings and thoughts about themselves and others, and ultimately in considering alternative explanations and ways of expressing themselves and coping.

2.3 Two Phases of Dyadic Developmental Psychotherapy

Dr. Hughes describes two phases of Dyadic Developmental Psychotherapy.

In the first phase, *"…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"* (Hughes, 2017, p. 595).

In the second phase, the therapist meets jointly with the youth and caregivers and actively facilitates a dialogue in a nonjudgmental, engaged conversational tone that helps the child develop a coherent autobiographical narrative.

2.4 Key Elements of DDP Process: PACE

The foundation of DDP is the therapist's manner, which seeks to develop a youth's reflective abilities and discussion of feelings. The therapist may wonder with them aloud in a light-hearted, curious way about what is underneath the feelings. Hughes uses the acronym PACE to describe the manner or attitude of the therapist and parent.

Click each of the four attributes to learn more.

Playful When Appropriate: Light, relaxed, smile, do the unexpected. Playfulness conveys a sense of hopefulness and generates a forward energy. Playfulness is not used as an effort to pull a person out of a negative emotional state.

Accepting: This means being accepting of thoughts, feelings, beliefs, wishes, memories, perceptions of behavioral events; nonjudgmental, unconditional regard (only behavior may be evaluated).

Curious: Not-knowing, being open and interested, act of discovery, surprise, "aha." Dr. Hughes describes curiosity as becoming a detective, not getting distracted by the symptoms, and experiencing the unconditional enjoyment of the child underneath the symptoms.

Empathic: Feeling felt, joined, in the world of the other.

2.5 Key Element: Intersubjectivity

The second foundational element of DDP is intersubjectivity. Intersubjectivity is the shared, reciprocal experience between the parent and child, whereby the experience of each has an impact on the experience of the other.

Dr. Daniel Siegel describes intersubjectivity as characteristic of an intense, intimate connection "in which each is able to 'feel felt' by the other" (Siegel, 1999, p. 117).

Let's look at intersubjectivity in action.

[Video Transcript]

[An intimate conversation between mother and daughter]

MOTHER: You win, huh? Tickle, tickle. Can you tickles? Ba, ba, ba, ba, ba, ba. Kutcha ca.

BABY: [Cooing].

MOTHER: Oh yeah.

BABY: [Cooing].

MOTHER: Yeah. What else?

BABY: [Babbling].

MOTHER: Yeah. What else honey?

BABY: [Cooing].

MOTHER: Yes. Yeah, look at you.

BABY: [Babbling].

MOTHER: Oh really? Kitchy, kitchy. Goosey, goosey, goosey, goosey. Goosey, goosey, goosey, goosey.

[End of Video]

Video published by Chris Moyer and obtained from: https://www.youtube.com/watch?v=9FeTK7ZXmVI.

2.6 Intersubjectivity vs. Broken Intersubjectivity

This video illustrates the non-verbal nature of intersubjectivity. In it, we see:

- Attunement: Mother and baby are in sync
- Joint attention: Mother and baby are jointly focusing on one another
- Shared attention: Both mother and baby want the connection

Remember the Still Face experiment that we saw in an earlier lesson of this module, when the mother stopped responding to the baby? In that interaction, all of the above conditions were broken.

2.7 Role of Intersubjectivity in DDP

Click each shape to learn how intersubjective experiences play a role in DDP.

1. The therapist and adoptive parent/guardian provide the intersubjective experiences for the child that were seldom present when the child experienced abuse and neglect.

2. The therapist must provide intersubjective experiences for the parent that help create a secure base within which the parent, child, and therapist can work together to create new and more therapeutic meanings for the child's experiences.

3. Whenever possible, the child's adoptive parent or guardian is an active participant in the session. The therapist provides the parent or guardian support and guidance in communicating thoughts, emotions, and intentions to their child.

4. The parent/guardian serves as the primary source of safety, security, and comfort while the child explores events, experiences, and emotions that may generate fear and shame.

5. For some families, the circle is extended from the primary caregiver(s) to the extended family and community as support, so they are not limited in facing circumstances alone.

2.8 Attachment Theory

DDP is based on attachment theory and research. It focuses on the rupture and repair of security.

This interactive repair is initiated by the adoptive parents or guardians and the therapist and communicates to the child that they do not have to face stressful events and emotional states alone.

2.9 Affective-Reflective Dialogue

Central to DDP is Affective-Reflective Dialogue. This technique engages adoptive parents and guardians in rhythmic dialogue with children that is both about feelings (affective) and memory (reflective).

2.10 Importance of Affective-Reflective Dialogue

Reflection of both feeling and memory is important because:

- When dialogue is reflective only, it tends to become intellectualization.
- When dialogue is affective only, it can only be catharsis.
- For those familiar with Cognitive Behavioral Therapy (CBT), it is similar to helping clients see the link between feelings and thoughts, and vice-versa.
- The goal of the dialogue is to facilitate a coherent narrative of the child's life: *"I can talk and think about my whole life without shutting down or feeling ashamed."*

2.11 Key Element: Attunement

A non-judgmental attunement to both thoughts and feelings communicated both verbally and non-verbally is foundational to the DDP process.

What does attunement look like between parents and children as they develop?

Here is a description of attuned parents, given by a mental health professional:
"*Attuned parents are great listeners. They refrain from offering advice, judgments, or comparisons. Quality listening soothes children better than any counsel or recommendations and fulfills two crucial childhood needs: the need to feel understood and the need to be validated. Attuned parents intuitively sense their kid's feelings. They know when their kids are happy, upset, angry, or depressed. They respond to their kids' needs directly*."

2.12 DDP Session Video

Let's look now at a typical DDP session. You will see two excerpts from a DDP session with Dr. Daniel Hughes, a mother, Karen, and her 17-year-old daughter, Tina. Prior to this session, Dr. Hughes met with both the mother and father, but the dad was unable to attend this session.

Tina experienced serious neglect due to parental substance abuse and domestic violence in her birth family and entered foster care at age 3. After 7 foster placements, she was adopted at age 9 into this family with 2 older siblings. Her mother described Tina as becoming very withdrawn from the family and angry when she became a teenager, which was around the same time her older siblings went to college.

At the beginning of this session, Tina was very irritated at being there, angry and reluctant to talk, saying they'd been to therapists before, and it never did any good. She asked why they had adopted her and discussed that she and her mom never really talked, and that when she saw some of her friends having fun with their moms, she wished she had that.

Watch these two clips that occur in the second half of their session.

[Video Transcript]

DR HUGHES: Why do you think when you were talking from your heart to your mom, she had tears in her eyes?

TINA: I don't know. I guess because she cares about me.

DR HUGHES: You're not sure?

TINA: I don't know. There's always that, I don't know, question.

DR HUGHES: Doubt. Yeah. Which one of us should ask her?

TINA: Do you care about me?

KAREN: I care about you so much. I love you just like the other two. I just don't know how to make you understand that.

DR HUGHES: So like you don't know how to show it in a way that Tina can experience it--

KAREN: That she'll get it.

DR HUGHES: --and feel it in her heart.

KAREN: Yes.

DR HUGHES: Yeah. Yeah. I bet, and this is, again, sort of the sad part of your hard start. Part of you just didn't know how to do it because you didn't have, what I said, is practice, or just sort of doing it like a little kid. But also, when a mom and a daughter can get to know each other so easily those first few years, about how to communicate I love you. And when you start when you're nine, it's harder to know how the other person will take it. And you might try it, and the other person doesn't feel it, and how to fix that then. When you're one or two or three, it's so easy to fix that and get it right, and so to get in sync like a dance together. You two never had that. You're sort of learning late.

TINA: Yeah.

DR HUGHES: Yeah. I don't think it's too late.

TINA: I don't know. I feel like I'm about to--I'm turning 18, and about to go off to college. I'm about to move out, so why try to get close now?

DR HUGHES: Yes. Great question. Any answers?

TINA: I don't know. I don't see any real point.

DR HUGHES: Yeah. Because you're focused on, you want a life of just moving out, exploring the world, going to college, having new friends, new ideas.

TINA: Yeah. Just keep going on.

DR HUGHES: On and on and on. Okay. But where do you see yourself on Christmas?

KAREN: I was just going to ask that. Thanksgiving. You know how everyone comes home for Thanksgiving.

TINA: Yeah. I never really thought about that.

DR HUGHES: Yeah. If you decide to marry someday, who do you want there?

TINA: I guess I always thought like a big wedding, so.

DR HUGHES: Yeah. Who would give you away?

TINA: I guess, I don't know. I guess my dad, my foster dad.

DR HUGHES: Your foster dad? Your adopted dad?

TINA: My adopted dad. Yeah.

DR HUGHES: Okay. Gosh, it's hard even--it sort of was a slip, but I think that slip was important, you calling your adopted dad your foster dad, because I think in your heart, in some ways you haven't really experienced a difference between adoption and foster care.

TINA: Yeah.

DR HUGHES: You really haven't trusted that this is different.

TINA: I still think like one day I'm going to wake up and they're just going to--my bags will be packed, so.

DR HUGHES: Oh, my goodness. Oh, my goodness. Will you tell your mom that?

TINA: Like, when I wake up, I get scared because I don't know if my bags are going to be packed and you're going to kick me out, and like I'm going be gone and I won't have you guys anymore.

KAREN: We never would do that.

DR HUGHES: I'm noticing you're not talking as much and you're listening more. I think, at the beginning, you were talking more because you were trying to make your daughter get close to you. You tried to make your daughter be a certain type of person even. Not in a mean way, but you were sort of desperate to have a daughter do real well, and you sort of weren't listening to her.

And I think what she's--and you listened today so well. And what she told you is things you've got to know about her. About her fears, about her sense of who she is, about her doubts about you, about her sense that she's not as good as your other kids. You had to know that, and you heard it. You listened. And you didn't fight and say she's wrong. You listened. And my guess is, is that your experience?

TINA: Yeah. It was nice. Yeah.

DR HUGHES: Could you tell her?

TINA: Yeah. It was nice having you listen to what I had to say, and not just forcing me to be like, oh, love me, love me.

DR HUGHES: That's it. She can talk about this better than I can. Well, it's her life. She ought to be able to talk about it better than I can. Plus, I'm not a 17-year-old girl.

[End of Video]

Video obtained and used with permission from: Developing Attachment – Family Therapy Examples with Dr. Daniel A. Hughes DVD.

2.13 DDP Video Takeaways

Click each number to hear a few things you may have noticed from the video excerpt.

1. Dr. Hughes uses affective-reflective dialogue to help Tina gain emotional access to some of her most painful and difficult feelings and perceptions.

2. Dr. Hughes responds to Tina's feelings with empathy and understanding before moving to a possible explanation - her difficult early life. This helps Tina to better understand her feelings and is moving toward co-construction of meaning.

3. He encourages Karen to become attuned to Tina's feelings and really listen to them, despite her being somewhat defensive and overeager to fix things.

4. Helping Tina put words to her experiences and encouraging her to talk directly to her mother provides opportunities for intersubjectivity, or her feeling felt by her mom.

5. Dr. Hughes takes a very active role in facilitating ongoing intersubjective experiences, but as the therapy progresses, it is likely that the family takes more initiative in directing the discussion.

3. Theraplay

3.1 Theraplay

Let's turn now to Theraplay.

3.2 Proactive, Intensive, Relationship Focused

Theraplay is a proactive, intensive, relationship-focused parent-child therapy for children and youth of all ages that:

- Is modeled on the natural patterns of healthy interaction between parents and child - the kind of interaction that leads to secure attachment and lifelong mental health
- Engages the child in a respectful, attuned, and playful way
- Uses guided interaction and reflection, focused on the parent becoming more available, responsive, and attuned to the child
- Incorporates principles that are based on attachment theory, intersubjectivity, and brain research

3.3 Goal of Theraplay

The goal of Theraplay is to enhance attachment, self-esteem, trust in others, and joyful engagement between a child and their primary caregivers.

Theraplay is modeled on the behavior of healthy parents with their children. Parents observe the therapist's modeling and are coached to be in charge in a nurturing way, to support their children when they are angry or upset, to use appropriate touch as part of nurturing, and to use challenge to build competence and self-esteem.

Theraplay activities foster engagement of child and parents through playful nurturing touch, such as feeding each other, putting lotion on each other's hands, thumb wrestling, and rocking a child in a blanket.

3.4 Components of Theraplay

Let's look now at the components of Theraplay. Click the numbers to learn more.

1. An intake interview is conducted without the child.

2. A variety of assessment tools may be used, including the Marschak Interaction Method, to assess the attachment between the child and each parent.

3. Feedback is provided to parents following the assessment.

4. Theraplay sessions lasting 30-45 minutes are held weekly, typically with ten to twenty sessions overall

5. Periodic parent-only meetings are held.

6. Approximately 4 Checkup sessions are conducted over time.

3.5 Theraplay Summary

Theraplay emphasizes building the parent-child relationship in the following ways:

1. A focus on parents and children enjoying one another
2. Parents and children being brought together to encourage and practice the playful, attuned, responsive interactions that characterize a healthy, secure relationship
3. Parents taking an active role with their child and better understanding and responding to their child's signals and underlying needs
4. Parents understanding their own experiences and attitudes that might get in the way of their being able to change old patterns and respond to their child's needs
5. The use of play with children with histories of neglect and abuse who often can't identify or inaccurately express their needs

To integrate Theraplay into your practice and learn more about the use of Theraplay with adolescents, go to the Theraplay website linked below or in the Resources tab.

4. Conclusion

4.1 Wrapping Up

In this lesson, we looked at additional attachment-based interventions with specific relevance to children with histories of trauma and attachment disruptions.

4.2 Your Journal

Please click on the journal page to write down your reflections on this lesson.

4.3 Journal Reflection

Reflecting on this lesson, what are your takeaways and how might you apply these in your practice?

4.4 Journal Response

Click the "Print Results" button to print and save your answers.

4.5 Conclusion

Congratulations! You have completed the last lesson in this module, Attachment, Child Development, and Mental Health – Promoting Security in Adoptive and Guardianship Families.

The next module focuses on understanding the impact of grief and loss experiences on children's and youth's mental health.