Attachment and Intersubjectivity in the Psychological Treatment of Intrafamilial Trauma
Tilburg, the Netherlands, April 19, 2013
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Dyadic Developmental Psychotherapy (DDP)

DDP is a treatment approach to trauma, loss, and/or other dysregulating experiences, that is based on principles derived from attachment theory and research and also incorporates aspects of treatment principles that address trauma.

DDP involves creating a safe setting in which the child can begin to explore, resolve, and integrate a wide range of memories, emotions, and current experiences, that are frightening, shameful, avoided or denied. Safety is created by insuring that this exploration occurs within an intersubjective context characterized by nonverbal attunement, reflective dialogue, acceptance, curiosity, and empathy. As the process unfolds, the client is creating a coherent life-story which is crucial for attachment security and is a strong protective factor against psychopathology. Therapeutic progress occurs within the joint activities of co-regulating affect and co-creating meaning.

Primary intersubjective experiences between a parent and infant contain shared affect (attunement), focused attention on each other in a way such that the child’s enjoyable experiences are amplified and his/her stressful experiences are reduced and contained, and a congruent intention to understand the other/be understood by the other. This is done through contingent, nonverbal (eye contact, facial expressions, gestures and movements, voice prosody and touch) communications. These same early parent-child experiences, fundamental for healthy emotional and social development, are utilized in therapy to enable the child to rely on the therapist and parents to regulate emotional experiences and to begin to understand these experiences more fully. Such understanding develops further through engaging in affective/reflective (a/r) dialogue about these experiences, without judgment or criticism. The therapist will maintain a curious attitude about past and present events and behaviors, facilitating the client’s ability to explore them to better understand their deeper meanings in his life and gradually develop a more coherent life-story. This process may be stressful for the client, so the therapist will frequently “take a break” from the work, go slower, provide empathy for the negative affect that may be elicited, and repair the treatment relationship.

The primary therapeutic attitude demonstrated throughout the sessions is one of playfulness, acceptance, curiosity, and empathy (PACE).

For the purpose of increasing the child’s psychological safety, his readiness to rely on significant attachment figures in his life, and his ability to resolve and integrate the dysregulating experiences that are being explored, a person who is a primary attachment figure to the client will be actively present. The role of the parent—or other attachment figure—in her child’s psychotherapy is the following:
1. Help him to feel safe.
2. Communicate PACE, both nonverbally and verbally.
3. Help him to regulate any negative affect such as fear, shame, anger, or sadness.
4. Validate his worth in the face of trauma, loss, and shame-based behaviors.
5. Provide attachment security regardless of the issues being explored.
6. Help him to make sense of his life so that it is organized and congruent.
7. Help him to understand the parents’ perspective and intentions toward him.
Frequently a person’s symptoms are his unsuccessful ways of regulating frightening or shame-based memories, emotions, and current experiences. Confronting a child to stop engaging in these symptoms may actually increase their underlying causes. In helping the child in therapy and at home to regulate the affect associated with the symptoms, and to understand the deeper meanings of the symptoms, we are increasing the likelihood that the symptoms will decrease. At the same time it may certainly be necessary to address the symptoms through increased daily structure and supervision or through applying natural consequences for them. Again, however, the issues will be addressed more effectively when done with PACE rather than routine anger, rejection, harsh discipline, or other shame-inducing actions.

When we are asking a child to address frightening or shame-based memories, emotions, and current experiences, we are asking him to engage in an activity that will be emotionally stressful. In do so it is crucial that we maintain an attitude characterized by PACE in order to insure that the client is not alone while entering that painful experience. The child has developed significant symptoms and defenses against that pain, most often because he was alone in facing it. When we help to carry and contain the pain with him, when we co-regulate the affect with him, we are providing him with the safety needed to explore, resolve, and integrate the experience. We do not facilitate safety when we support a child’s avoidance of the pain, but rather when we remain emotionally present when he is addressing and experiencing the pain.

For a caregiver and therapist to remain present for a child during periods of dysregulation, it is important for them to have resolved any similar issues from their own attachment histories. The significant adults in the child’s treatment need to address—in their own lives—any areas of fear or shame that are similar to what they are asking the child to address. Individual or joint treatment for the parent(s) may be necessary prior to, instead of, or during this family-focused treatment.

The following statements reflect routine features of DDP:

1. Playful interactions, focused on positive affective experiences, are never forgotten as being an integral part of most treatment sessions, when the client is receptive. When the client is resistant to these experiences, the resistance is met with PACE.
2. Shame is frequently experienced when exploring many experiences of negative affect. Shame is always met with empathy, followed by curiosity about its development, organization, exceptions, management, and impact on the narrative.
3. Emotional communication that combines nonverbal attunement and reflective dialogue and is followed by relationship repair when necessary, is the central therapeutic activity. All communication is “embodied” within the nonverbal.
4. Resistance is addressed and met with PACE, rather than being confronted.
5. Treatment is directive and client-centered. Directives are frequently modified, delayed, or set-aside in response to the child’s response to the directive.
6. The therapist is responsible for insuring the rhythm and momentum of the session. The therapist insures the development of a coherent story line through his matched, regulated, affect, accepting awareness, and clear intentions.

The Double-Helix: Attachment and Intersubjectivity
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Attachment & Intersubjectivity: Safety and Reciprocal Exploration
Within the context of safety, intersubjective exploration becomes possible
Through intersubjective exploration, attachment security is enhanced.

Within intrafamilial trauma (various acts of abuse and neglect):

- Safety is destroyed and developmental patterns become disorganized.
- Intersubjective explorations are reduced and avoided.
- The self is an object to the other, not an intersubjective partner.
- Traumatic events are not explored and experienced in an integrative, coherent, intersubjective manner. They are not assimilated into the autobiographical narrative.
- Traumatic events create dissociation, as do subsequent memories of such events, thus causing rigid avoidance or “re-traumatization”.

Psychological treatment of intrafamilial trauma:

1. The therapist becomes a source of safety (available, sensitive, responsive, repair).
2. Within the context of safety, the therapist becomes actively engaged with the client through an attitude of playfulness, acceptance, curiosity and empathy.
3. Primary intersubjective experiences are created in which the client and therapist are having a reciprocal affective/reflective influence on each other.
4. The intersubjective attention turns toward the client’s trauma, with the therapist re-establishing safety and the active engagement of acceptance, curiosity, and empathy.
5. Secondary intersubjective experiences are created in which the client begins to experience the trauma through the experience (matched affect, attention, and intention) of the therapist.
6. Within safety and intersubjectivity, the emerging affect is co-regulated.
7. Within safety and intersubjectivity, the emerging experience is re-organized.
8. The original event is no longer “traumatic” (i.e. able to cause dissociation and disorganization) but is now able to be integrated into the autobiographical narrative in a coherent manner.
9. The client is now able to remember the original event in an affective/reflective manner and continue to re-organize the experience of the event through its exposure to other experiences that exist within the narrative.

DEVELOPMENTAL TRAUMA DISORDER
Toward a rational diagnosis for children with complex trauma histories
Bessel van der Kolk, MD
Psychiatric Annals 35:5 May 2005, Pp.401-408

“Traumatized children rarely discuss their fears and traumas spontaneously. They also have little insight into the relationship between what they do, what they feel, and what has happened to them.” P.405
“The PTSD diagnosis does not capture the developmental effects of childhood trauma:
The complex disruptions of affect regulation;
The disturbed attachment patterns;
The rapid behavioral regressions and shifts in emotional states;
The loss of autonomous strivings;
The aggressive behavior against self and others;
The failure to achieve developmental competencies;
The loss of bodily regulation in the areas of sleep, food, and self-care;
The altered schemas of the world;
The anticipatory behavior and trauma expectations;
The multiple somatic problems, from gastrointestinal distress to headaches;
The apparent lack of awareness of danger and resulting self endangering behaviors;
The self-hatred and self-blame;
The chronic feelings of ineffectiveness.” P. 406

Treatment Implications “Treatment must focus on three primary areas:
  1. Establishing safety and competencies  2. Dealing with traumatic re-enactments
  3. Integration and mastery of the body and mind.” P. 407

COMPLEX TRAUMA IN CHILDREN AND ADOLESCENTS
A. Cook, J. Spinazzola, J. Ford, C. Lanktree, M. Blaustein, M. Cloitre, R. DeRosa,
R. Hubbard, R. Kagen, J. Liautaud, K. Mallah, E. Olafson, B. van der Kolk
Psychiatric Annals, 35:5  May, 2005, 390-398.

Domains of Impairment in Children Exposed to Complex Trauma

Six Core Components of Complex Trauma Intervention:
5. Relational Engagement  6. Positive Affect Enhancement

GENERAL PATTERNS of CHILDREN with Trauma-Attachment Problems

Impaired Development Symptom Patterns

Minimal
  joy, humor
  reciprocal enjoyment (fun, love)
  eye contact
  selective attachment

Pervasive Fear and Shame
  Excessive need to Control
  Oppositional-Defiant Behaviors
  Affect Dysregulation
    rage, terror, despair
indiscriminately charming
empathy
guilt/remorse
emotional communication
inner-state language re: self & other
cause/effect thinking
awareness of bodily functions
appropriate physical boundaries
continuing sense of self across
various experiences and moods.
(Each deficit often creates resistance to the experience.)

Hurting others and self:
emotional and physical
Poor response to discipline,
frustrations, responsibilities
Lies, Excuses, Blaming
Good/Bad Splitting
Sense of entitlement; demanding
Victimhood  Identity
Destructive, stealing, hoarding
Disingenuous affect & behavior
Dissociation
Hypervigilance
Avoidance of specific thoughts/
feelings/behaviors

These patterns reflect failings in the developmental differentiation and integration of one’s basic body-self, affect, behavior, and cognition, that is occurring during the first three years of life. Each symptom most likely reflects a combination of a lack of affective attunement, a sense of terror due to abusive trauma, and excessive shame.

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Core Components of Dyadic Developmental Psychotherapy

The following features of DDP are common to central components of much empirically-based psychotherapy:

1. Therapeutic Relationship: Facilitated through safety and intersubjective communications

2. Empathy: Experienced and expressed nonverbally and verbally

3. Acceptance: The inner life of the client is always accepted

4. Curiosity: an active, non-intrusive fascination with the client: “who are you?” “What does that mean?” “I wonder if, maybe, sometimes. . .”
5. Gradual Exposure: within Affective-Reflective Dialogue and the co-regulation of affect and co-creation of meaning, shame and terror events are gradually explored, within a follow-lead-follow paradigm.

6. Auto-Regulation & Self-Soothing: Emerges following and along with the co-regulation of affect, reciprocity, breathing, sensate-focusing.

7. Coping Skills: Emerges following and along with the joint discovery of the meaning of behaviors, with practice, self-talk, identifying attributions, narrative development.

8. Emotional Processing: Emerges following and along with the joint experience of emotions and their affective expressions so that the inner world of the child is now able to be identified with words, expressed, and regulated.

9. Communication Skills: Emerges following and along with the joint expression of experience through dialogues, practice, coaching, role-playing.

10. Social Skills: Emerges following and along with joint nonverbal and verbal communication; meaning-making, and identifying social cues for attributions.

11. Parent Consultation In context of the parent’s reflection on self and child, experience of and coaching in PACE, discipline with empathy, success/strength focused, structure and supervision.

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CORE ASSUMPTIONS ABOUT CERTAIN BEHAVIORS OF CHILD

Argue, complain, control, rage, withdraw, not ask for help, not show affection, bang head
To sleep, scream over routine frustrations, constant chatter, avoid eye contact, lie, Steal, gorge food, socialize indiscriminately
Under the Behavior
Conviction that only self can/will meet own needs
Never feeling safe
Pervasive sense of shame
Conviction of hopelessness and helplessness
Fear of being vulnerable/dependent
Fear of rejection
Inability to self-regulate intense affect—positive or negative.
Inability to co-regulate affect—positive or negative.
Felt sense that life is too hard. Feeling “invisible”
Assumptions that parents’ motives/intentions are negative
Lack of confidence in own abilities
Lack of confidence that parent will comfort/assist during hard times.
Inability to understand why s/he does things.
Need to deny inner life because of overwhelming affect that exists there.
Inability to express inner life even if he wanted to.
Fear of failure                         Fear of trusting happiness
Routine family life is full of associations to first family
Discipline is experienced as abuse/neglect
Inability to be comforted when disciplined/hurt.

CORE ASSUMPTIONS ABOUT CERTAIN BEHAVIORS OF PARENTS
Chronic anger, harsh discipline, power struggles, not ask for help, not show affection, difficulty sleeping, appetite problems, ignoring child, remaining isolated from child, reacting with rage & impulsiveness, lack of empathy for child, marital conflicts, withdrawal from relatives and friends, chronic criticism.
Under the Behavior
    Desire to help child to develop well.    Love and commitment for child.
    Desire to be a good parent.     Uncertainty about how to best meet child’s needs.
    Lack of confidence in ability to meet child’s needs.
    Specific failures with child associated with more pervasive doubts about self.
    Pervasive sense of shame as a parent.
    Conviction of helplessness and hopelessness.
    Fear of being vulnerable/being hurt by child.   Fear of rejection by child as a parent
    Fear of failure as a parent.          Inability to understand why child does things.
    Inability to understand why self reacts to child.
    Association of child’s functioning with aspects of own attachment history.
    Feeling lack of support and understanding from other adults.
    Felt sense that life is too hard.  Assumptions that child’s motives/intentions are negative.
    Feeling that there are no other options besides the behavior tried.

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Characteristics of Affective-Reflective Dialogue
1. Attitude of playfulness, acceptance, curiosity and empathy. These factors provide the momentum for the therapeutic, transforming quality of the dialogue. The therapist actively conveys through these qualities that all memories, affective states, and events can be accepted, understood, and integrated into the narrative. Breaks are easily repaired and the flow within nonverbal/verbal, affect/reflection, follow/lead/follow proceeds within a sense of safety and with an openness to the discovery of new aspects of self and relationship. The attachment figures also use PACE. No lectures. PACE embodies features of mindfulness and might be considered to foster intersubjective mindfulness.
   Playfulness: light, relaxed, exaggerated (affect/cognition), smile, do unexpected
   Acceptance: Of thoughts/feelings/beliefs/wishes/memories/perceptions
   re: behavioral events.  Nonjudgmental, unconditional
   Curiosity: not-knowing, open, interested, act of discovery, surprise, “a ha”.
   Empathy: feeling-felt, joined, in the world of the other. Giving expression to affect vitality. Compassion and loving kindness.

2. Follow-lead-follow. The therapist follows the lead of the family member, joins, is curious, and responds. Therapist leads into related area, elaborates, wonders about implications and follows whatever response the other gives. When necessary therapist leads into related areas that are being avoided, while then following the client’s response to that lead. This process parallels the parent-infant dance.
3. Connection-break-repair. In therapy, as in all relationships, there are frequent breaks in the felt-sense of connection due to many factors. The therapist notes the breaks, accepts them, understands them, and facilitates interactive repair. Breaks are not to be avoided but rather are utilized for their meaning and as the source of new change opportunities in the relationship and the self. As the b/e is normalized, given the experience of it, the shame is reduced and the b/e is integrated into the narrative.

4. Nonverbal communication. For toddlers verbal communication flows naturally from nonverbal communication. For all of us nonverbal communication is the primary means we have of giving expression to our inner lives as well as to become aware of the inner lives of others. The therapist needs to be sensitively aware of the nonverbal expressions of family members, help to make these expressions verbal, and help to create congruence between the nonverbal and verbal. Nonverbal expression/communication:
   - Matched, cross-modality vitality affect
   - Congruent with verbal communication
   - Awareness of other’s nonverbal meaning
   - Clear, nonambiguous expressions
   - Flowing—gradual, regulated, changes
   - Gaze—direct, warm, open, interested, responsive
   - Voice—variable, responsive, relaxed, open, animated
     - thoughtful, alive, empathic.
   - Gestures—animated, expansive, dramatic, responsive
   - Posture—open, moving/leaning forward

5. Affect & Reflection: balance and integration. Meaningful dialogue contains a blend of affect and cognition, conversation and reflection, which holds the interest of the participants and co-creates the meanings of the narratives. All memories/experiences and affective states including attachment histories of parent/child are included. The therapist is aware of the affect/reflection components of the here-and-now expressions and facilitates their balance, congruence, and integration.

   Verbal expression/communication
   - Expression of experience of B/E
   - Coherent, comprehensive, succinct
   - Self/other balance
   - Blend of specific/general
   - Past/Present/Future
   - Turn-taking
   - Organized/focused
   - Balance of Affective/Reflective

6. Co-creation of new meanings through primary and secondary intersubjectivity. For the dialogue to be effective, affect attunement, joint attention, and congruent intentions need to be present. When not present, the break will be repaired and communication will not continue without the intersubjective matrix. Communicating to attachment figure intensifies affect,
understanding and integration, while facilitating security of attachment. New Meanings regarding b/e and associated thoughts/feelings emerge.

Affect: Interests & Joy toward objects/others/self
Fear, sadness, anger
Shame & Guilt
Response to PACE

Cognitions/Reflective abilities/content
Child—Parent/Partner—friend
Trauma
Sense of autobiographical narrative
Choices/plans/intentions/priorities
Sense of efficacy
Successes/failures
Understanding/Explanations/Patterns/General Awareness

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REFERENCES


