Dyadic Developmental Psychotherapy: A multi-year Follow-up

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THE DYADIC DEVELOPMENTAL PSYCHOThERAPY PRIMER: AN EVIDENCE-BASED, EFFECTIVE, AND EMPIRICALLY VALIDATED TREATMENT

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ABSTRACT:

This monograph describes Dyadic Developmental Psychotherapy, its primary components and the differential use of those components in the different stages of treatment. It is intended to provide an overview of Dyadic Developmental Psychotherapy. The empirical research and other materials demonstrating the efficacy and evidence-base of this approach will be summarized. The use of this treatment with families who have children who have experienced complex trauma will be described. This approach was originally developed for use with adopted and foster children and has now been demonstrated as valuable as a general treatment model.

The use of this model in residential treatment settings will also be described. Case examples and excerpts from treatment sessions will be used to illustrate the differential use of components in different phases of treatment and other aspects of this treatment.

INTRODUCTION

This monograph describes Dyadic Developmental Psychotherapy, its primary components, and the differential use of those components in different phases of treatment. The empirical research demonstrating the efficacy and evidence-base of this approach is summarized. Dyadic Developmental Psychotherapy was developed originally as an approach to treat adopted and foster children who have experienced complex trauma (Hughes, 2007). It is now been demonstrated to be a valuable as a general treatment model. Dyadic Developmental Psychotherapy is a family therapy grounded in attachment theory (Becker-Weidman, 2010; Becker-Weidman, 2011; Hughes, 2007). The treatment has been used in a variety of settings including inpatient, residential treatment centers, group homes, foster care homes, clinic settings, outpatient settings, and in private practices.

Dr. Hughes developed this model over several years, beginning in the late 1980’s. Dyadic Developmental Psychotherapy continues to evolve as research, described below, and clinical practice have led the way toward a richer and deeper understanding of the factors that help families and children. As the creator of this model, Dr. Hughes has written several texts that describe this model (Hughes, 2004; Hughes, 2006; Hughes, 2007). These texts present Dyadic Developmental Psychotherapy as a model for treatment that is firmly grounded in

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shared experiences and the healing power of emotions within the therapeutic setting. The model has now been extended and can also be described as Attachment Focused Family Therapy because of its broad applicability to a variety of settings and for a variety of clients. Dyadic Developmental Psychotherapy can be thought of as the application of this approach to families where disorders of attachment and trauma are central difficulties.

This monograph is intended to provide the reader with an overview of the practice of Dyadic Developmental Psychotherapy. By explicating the primary principles, components, and phases of treatment, this monograph will help ensure continued integrity to this model of treatment as taught at the Center For Family Development and at other training institutes. Integrity in the application of the model facilitates reliability of delivery across a spectrum of practitioners and facilitates the highest quality research.

After absorbing the material in this monograph the reader should have a clearer understanding of the practice of Dyadic Developmental Psychotherapy, and how one can practically use it. Advanced clinicians will find this useful to develop a more focused understanding of the work. Therapists, parents, residential treatment staff, social workers, psychologists, child welfare workers, and many others should also find this monograph useful. It will provide them with a deeper understanding of the practice of Dyadic Developmental Psychotherapy. The practice of Dyadic Developmental Psychotherapy is both art and science. The use of self is central to this approach, and one should be able to implement Dyadic Developmental Psychotherapy in a manner consistent with individual personality, history, and pattern of attachment; that is the art.

**DYADIC DEVELOPMENTAL PSYCHOTHERAPY**

The principles of Dyadic Developmental Psychotherapy include the following:

First, the maintenance of a contingent, collaborative, sensitive, reflective, and emotionally empathic relationship between the therapist and client is a primary principle of treatment. The therapist is responsible for creating and maintaining positive concordant intersubjective experiences (Stern, 1985; Trevarthen 2001) with the client and for helping caregivers create these experiences with their children. Intersubjectivity is a comprehensive emotional, reflective, and behavioral experience of the other. It is the discovery within the relationship of the other. It emerges from shared emotions (attunement), joint attention and awareness, and shared complimentary intentions. Creating and maintaining an alliance is the vital first phase of treatment. The creation and maintenance of an alliance is necessary for the creation of a secure base, which allows for exploration, which is necessary for integration and ultimately, healing.

Second, the caregivers’ and therapist’s state of mind with respect to attachment should be organized and largely resolved before beginning treatment with the child. The therapist’s and the caregiver’s state of mind with respect to attachment has been found to be very important for treatment success (Tyrell et. al., 1999; Dozier, et al. 2001).

Third, PACE and PLACE describe the basic stance of the therapist and caregiver. PACE describes the therapist’s responsibility for creating a healing pace of treatment by being playful, accepting, curious, and empathic. PACE allows the therapist to generate and regulate the emerging emotional experiences that are explored in treatment. PLACE refers to the
caregiver’s responsibility for creating a healing place or environment by being playful, loving, accepting, curious, and empathic. Fourth, interactive repair is another important principle of treatment. Inevitable conflicts, misunderstanding, and mistakes that occur in all relationships are directly addressed and repaired. This process facilitates emotional regulation. It is the responsibility of the adult to initiate and model this process. Fifth, “resistance” is treated with PACE. Resistance is viewed as reflecting fear, shame, and the child’s past negative experiences with caregivers. “Resistance” is not a pejorative and should not be interpreted as negative. Resistance is viewed as an expression of fear and may reflect that the therapist has gone too far, or too fast, for the client. Resistance may be viewed as an adaptive strategy for managing upsetting and disturbing affect. The response to resistance will then be interactive repair or more follow and less lead of the follow-lead-follow component, which is described below. Sixth, the therapist continually assesses (Becker-Weidman, 2010a) the caregiver’s readiness to be a sensitive, responsive, insightful, reflective, and committed attachment figure for the child. If the therapist has concerns about the child’s emotional and psychological safety, the therapist will continue to work with the caregiver without the child to help the caregiver resolve whatever barriers exist for the caregiver’s creating this secure base and sense of safety for the child. Parents and other caregivers are central to Dyadic Developmental Psychotherapy. Caregivers are the keystone for how treatment proceeds and its outcome. In many respects the best predictor of outcome is not “how disturbed” is the child, rather it is the caregivers (Becker-Weidman, 2010, Becker-Weidman, 2010a):

- State of mind with respect to attachment
- Reflective function and reflective abilities
- Commitment
- Insightfulness
- Sensitivity

Evidence-Based, Empirically Validated, Effective Treatment

Dyadic Developmental Psychotherapy is a fusion of several evidence-based and empirically validated principles and methods (Becker-Weidman, 2010; Becker-Weidman, 2011; Becker-Weidman and Hughes, 2008). Dyadic Developmental Psychotherapy is an effective, evidence-based (Craven and Lee, 2006) and empirically validated treatment. Craven and Lee (2006) determined that Dyadic Developmental Psychotherapy is a supported and acceptable treatment (category 3 in a six level system). However, their review was only based on results from a partial preliminary presentation of two ongoing follow-up studies, subsequently completed and published in 2006 (Becker-Weidman, 2006a; Becker-Weidman, 2006b). The first study (Becker-Weidman, 2006a) compared the results of Dyadic Developmental Psychotherapy with other forms of treatment, “usual care”, one year after treatment ended. A second study (Becker-Weidman, 2006b) extended these results to four years after treatment ended. Based on the Craven and Lee classifications (Saunders et al. 2004), inclusion of those studies would have resulted in Dyadic Developmental Psychotherapy being classified as an evidence-based category 2, “Supported and probably efficacious”. Since the development of Dyadic Developmental Psychotherapy, there have been two empirical studies demonstrating the effectiveness of Dyadic Developmental Psychotherapy published by this author (Becker-Weidman, 2006a, Becker-Weidman, 2006b).
These two studies each had a sample size of 64. The first study (Becker-Weidman, 2006a) compared two groups of children who met the criteria for Reactive Attachment Disorder and Complex Trauma (Cook, et. al., 2003; Cook, et. al., 2005). The experimental group received Dyadic Developmental Psychotherapy at The Center for Family Development, while the control group received other standardized treatments by other qualified professionals at other clinics. The two groups were matched and were not significantly different on a variety of variables including age, gender, length of time in placement or adoption, and their pre-treatment scores on the Child Behavior Checklist (CBCL) (Ackenbach, 1991) and various other demographic variables. Both groups of children had scores in the clinical range on the CBCL before treatment. One year after treatment ended, the children in the experimental group (Dyadic Developmental Psychotherapy treatment) had post-test scores on all scales of the CBCL that were in the normal range and that were statistically significantly different (lower) than their pre-test scores. The children in the control group had post-test scores that remained in the clinical range and there were not statistically significantly different from their pre-test scores.

The second study (Becker-Weidman, 2006b) followed these same families for four years after treatment ended. This study found that the children who had received Dyadic Developmental Psychotherapy continued to have CBCL scores in the normal range, remaining statistically significantly lower than their pre-test CBCL scores. Children in the experimental group, who actually continued to receive other treatment from other providers at other clinics, not only had CBCL scores that remained in the clinical range, but on four of the CBCL scales their scores were statistically significantly worse: Anxious/Depressed, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior.

The following two tables summarize the results of the two empirical studies cited above. Dyadic Developmental Psychotherapy is an affect-focused family therapy based on Attachment Theory (Bowlby 1980, 1988; Holmes, 1993) and draws on the best of several previously established, evidence-based approaches, methods, and techniques that have a strong evidence base. Dyadic Developmental Psychotherapy uses a variety of principles, interventions, and methods with well researched and empirically supported foundations. For example, Dyadic Developmental Psychotherapy is consistent with the basic principles of effective treatment for complex trauma (Cook et al., 2003, 2005). Cook, et. al., identify six core components of complex trauma interventions: ‘safety, self-regulation, self-reflective information processing, traumatic experience integration, relational engagement, and positive affect enhancement’ (Cook et al, 2005 p. 395). Dyadic Developmental Psychotherapy emphasizes each of these six core components. Specific components, methods, and principles of Dyadic Developmental Psychotherapy that have good empirical support and are shared with other treatment approaches (Orlinsky, Grawe, and Parks, 1994).
Table 1. Statistical Analysis of Treatment Group

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>2nd post-test</th>
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<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
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<tr>
<td>CBCL syndrome scale scores</td>
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<td></td>
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<tr>
<td>Withdrawn</td>
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<td>11.8</td>
<td>54</td>
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<tr>
<td>Anxious/depressed</td>
<td>62</td>
<td>10.5</td>
<td>58</td>
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<tr>
<td>Social problems</td>
<td>67</td>
<td>9.7</td>
<td>59</td>
</tr>
<tr>
<td>Thought problems</td>
<td>68</td>
<td>9.5</td>
<td>65</td>
</tr>
<tr>
<td>Attention problems</td>
<td>72</td>
<td>12.5</td>
<td>57</td>
</tr>
<tr>
<td>Rule-breaking behavior</td>
<td>69</td>
<td>6.9</td>
<td>53</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>71</td>
<td>9.1</td>
<td>55</td>
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Table 2. Statistical Analysis of Control Group

<table>
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<tr>
<td></td>
<td>Mean</td>
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<td>CBCL syndrome scale scores</td>
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<td>Rule-breaking behavior</td>
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<td>Aggressive behavior</td>
<td>70</td>
<td>10.2</td>
<td>68</td>
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</tbody>
</table>

* Statistically significant

Other elements of Dyadic Developmental Psychotherapy that have been found to have a strong evidence-base in the psychotherapy outcome research literature include the following elements.

Frist, affect arousal has been found to be important for positive outcomes in psychotherapy (Beutler et al., 2004). Affect arousal (achieved by the Dyadic Developmental components of follow-lead-follow, affective/reflective dialogue, and PACE, among other components, is managed within the context of the co-regulation of affect and interactive repair) is a significant theme in Dyadic Developmental Psychotherapy.

Second, explaining how the past may be continuing to affect present behavior, emotions, and meanings has been found to be an effective mode of treatment in 63% of studies reported (Orlinsky et al., 1994).

Third, forming and maintaining a therapeutic alliance is a core principle of Dyadic Developmental Psychotherapy. The therapeutic alliance has been shown to be vital to successful treatment outcome (Norcross 2001; Lambert and Ogles 2004). The use of PACE is
expected to help facilitate this. There is a significant positive association between outcome
and the therapeutic bond (Lambert and Ogles, p. 308). In looking at the therapist’s
contribution to the therapeutic alliance, a significant positive association with outcome was
also found. “The therapist’s contribution was positively associated with outcome 67% of the
time and never negatively implicated” (Lambert and Ogles, p. 321). “The strongest evidence
linking process to outcome concerns the therapeutic bond or alliance” (Lambert and Ogles, p.
360).

Fourth, acceptance is a significant component of Dyadic Developmental Psychotherapy
and is a significant element in the “PACE” attitude. Affirmation (acceptance, non-possessive
warmth, or unconditional positive regard) was found to be a significant factor in positive
therapeutic outcome. Acceptance involves an entirely nonjudgmental stance directed towards
the thoughts, feelings, intentions, etc., that characterize the child’s ‘inner life’. Described
differently, the creation of concordant intersubjective experiences or the level of empathic
understanding and personal rapport has a substantial history of having been shown to be
important factors in positive outcome. There is now, “general acceptance of empathy as a
factor in outcome, which has been clearly confirmed again in a current meta-analysis”
(Orlinsky et al. 2004, p. 350).

Fifth, Dyadic Developmental Psychotherapy has both cognitive and experiential
dimensions. Both these dimensions have a large body of empirical support. “The existing
research is now more than sufficient to warrant a possible valuation of experiential therapy in
four important areas: depression, anxiety disorders, trauma, and marital problems,” (Elliott et

Sixth, relationship factors are important for successful treatment outcome (Lambert and
Ogles 2004). The development of a secure base from which exploration can occur requires
the development and maintenance of an alliance. It is these common factors across therapies
that account for a significant portion of treatment outcome. “A therapeutic relationship that is
characterized by trust, warmth, understanding, acceptance, kindness, and human wisdom”
(Lambert and Ogles 2004, p. 180), is described as a broad set of factors that are common
across therapies and associated with client improvement. These are the very same factors that
form the core attitude of Dyadic Developmental Psychotherapy; PACE.

Overall such factors as empathy, the capacity for reflection, intersubjective sharing of
experience, the therapeutic alliance, furthering reflection, deepening emotional processing,
enhancing adaptive skills, developing and maintaining the therapeutic bond, therapist
affirmation, communication attunement, and the bond of relatedness between therapist and
patient are all important factors in psychotherapy outcome and are all important components
of Dyadic Developmental Psychotherapy.

**ATTACHMENT-FACILITATING PARENTING: CENTRAL FOR
TREATMENT SUCCESS**

In this monograph I use the term parents in the broad sense to mean care-givers: parents,
relatives caring for a child, and child care workers in residential treatment centers, for
example. This principles, components, and methods of Dyadic Developmental Psychotherapy
are used in the same manner by all these primary caregivers. Whether the primary attachment
figure is a birth-parent, adoptive-parent, foster-parent, kinship placement, or residential treatment center staff member, the primary attachment figure can use this approach to facilitate healing.

Parents are the keystone of good treatment outcomes. The proper preparation of caregivers to engage in treatment and create a healing PLACE (an acronym described below, standing for Playful, Loving, Accepting, Curious, and Empathic) is a necessary and essential component of the treatment process. This section provides a brief overview of this necessary and essential component. A much more detailed account of parenting and parent training consistent with Dyadic Developmental Psychotherapy can be found in the book, Attachment Parenting (Becker-Weidman and Shell, 2010) and in several other publications (Becker-Weidman, 2010; Becker-Weidman, 2011; Becker-Weidman, 2006c; Hughes, 2007; Hughes, 2009; Ring 2011).

Helping caregivers see below surface behavior and catch a glimpse of the underlying emotions and perceptions driving that behavior are the first step in helping parents change the lens through which they view their child. The parent’s assumptions and understandings about the child’s motives, intentions, and purposes directly determine how the parent views the child and the experience, and this directly affects how the parent feels about the child and the experience. For example, a child is found in her room with her brother’s juice box and other food items in the closet, behind some boxes. If the parent’s understanding of this situation is that the child “stole” the items and was hiding, and being sneaky, the parent will feel one way toward the child, probably annoyed and frustrated. If this has been the umpteenth time the parent told the child not to steal her brother’s juice boxes and hide food in her closet, and each time the child agrees with the parent not to do that, the parent may now be feeling quite upset with the child. On the other hand, if the parent understands the child’s behavior as being driven by a different set of motives and intentions, the parent will feel quite differently. For example, if the parent goes deeper and recalls that the child has grown up in settings in which there was inconsistent caregiving, a lack of any reliable source of food, and no one to help the child, then the parent may view the child’s behavior as reflecting that experience and being driven by fear of going hungry and a belief that the only one she can count on is herself. In this instance, the parent may have much more empathy for the girl and respond accordingly. By helping parents see below the surface and understand the forces driving behaviors, the therapist can help parents feel differently and then act differently, more therapeutically, toward their child.

“All behavior is adaptive” and “Kind Attributions” are two important principles for the therapist to communicate to the caregivers. All behavior is adaptive refers to the notion that one develops in response to people, situations, relationships, and experiences that shape how a person feels and acts. Behaviors develop that are adaptive to the situation in which those behaviors originally formed. In many respects “symptoms” can be viewed as behaviors that were adaptive and that evolved in response to a specific set of circumstances, but these same behaviors are now “symptoms” because they are now occur in new situations in which the behaviors are no longer adaptive. The new situations are inhibited from having an effect on these old behaviors if the old experiences evoked the stress response system on a chronic basis. In these instances it is the “survival brain” and not the “learning brain” that is primarily active. The survival brain does not function to incorporate new information, experiences, or emotions. This is vital for caregivers to understand, so that they can focus on creating a healing PLACE at home with a deep sense of safety: emotional, psychological, and physical.
The principle of *kind attributions* is related to the principle of *all behavior is adaptive and has meaning*. This principle is that when in doubt, attribute benign motivations or intentions to the client. Helping a parent have kind attributions regarding their child’s intentions is more likely to lead to the creation of positive concordant intersubjective experiences and the creation of safety and security, which is most conducive to the functioning of the learning brain. This same principle applies to the therapist’s understanding and relationship with the parents. While the behavior may not be laudable, most often the deeper intention is more positive. There are several other important elements of attachment facilitating parenting that are grounded in Dyadic Developmental Psychotherapy that the therapist will want to communicate to the parents. Parents can certainly learn these various elements by reading books or articles, and therapists can “train” parents using psycho-educational models. However, early in treatment, and this is when the material is imparted, it is useful to remember that the therapist’s focus is on building and maintaining a secure base. At times just telling the caregivers what to do and why can be effective. Often, even within that first session, the parents feel enough safety and comfort that direct instruction is appreciated and effective. However, frequently there are times when the therapist will find it therapeutic to evoke the material and principles from the parents by exploring with the parents what is their thinking, their feeling states, their experiences as parents, and how they understand their child. Using PACE and follow-lead-follow, the therapist can explore all of these areas and help parents come to a deeper understanding of themselves and of their child.

**Phases of Treatment**

This section briefly summarizes the phases of Dyadic Developmental Psychotherapy. The phases occur in a recursive and repetitive manner, much like the phases of the moon. The phases overlap and occur in a cyclical manner and so should not be considered discrete or rigidly defined. The value of considering these phases is that the various components of Dyadic Developmental Psychotherapy are used differently in the different phases of treatment (Becker-Weidman, 2010; Becker-Weidman, 2011). Like a continual spiral, development and treatment continue ever deeper. As treatment proceeds, the therapist must continually work to maintain the alliance, explore to achieve integration and healing, and then ensure that the alliance remains strong enough to proceed. Exploration and integration can lead to a more secure alliance, which will allow for deeper exploration and further integration and healing. Healing often allows for a stronger alliance to develop, which will facilitate further integration. While the general principles remain constant, each phase requires a different mix of the components of Dyadic Developmental Psychotherapy. It is the application of the various components of Dyadic Developmental Psychotherapy in a differential manner that is the art of this treatment. One phase may last several sessions, and many phases may be present in one session. Healing may begin in the very first session, for example. The phases described here are defined in terms of attachment theory: developing and maintaining the alliance (secure base), exploration, integration, and healing. An alliance is necessary to create and maintain a secure base. A secure base is necessary to begin exploration. Exploration leads to integration. Integration is the basis for healing.
DEVELOPING THE ALLIANCE

Developing the alliance is a critical phase of treatment. Without an alliance, there can be no exploration, integration, and healing. Children and parents or carers with unresolved traumas and hurts will have a more difficult time forming an alliance with the therapist. In these instances, the therapist will have to pay particular attention to developing the alliance and relationship.

Creating a secure base in treatment becomes the therapist’s primary task. There are four primary tasks in this phase:

- Forming a therapeutic alliance
- Developing a "treatment contract." Why are we here? Why are we meeting? What are we doing here?
- Forming initial theories of behavior: the meanings to be explored.
- Creating a secure base

While all components of Dyadic Developmental Psychotherapy may be used, a few stand out as more salient in this phase: PACE, the “follow” dimension of follow-lead-follow, intersubjectivity, and the co-regulation of affect. Creating a secure base and then maintaining that alliance is a necessary and essential precursor to beginning the Exploration phase. Therapist’s use of self is also an important component in creating a secure base in treatment. The therapist must be emotionally engaged in the intersubjective experiences within treatment and this requires good self-awareness, reflective abilities, and insightfulness on the part of the therapist. In working with parents and careers, it is also important to help them appreciate the importance of the construct, “it’s about connections, not compliance,” (Becker-Weidman, 2010, Hughes and Becker-Weidman, 2010).

MAINTAINING THE ALLIANCE

Maintaining the Alliance is a phase that the therapist must attend to throughout treatment. At times it is in the forefront of the work, and at other times it recedes into the background. Focusing on this phase becomes particularly important when there has been some breach in the alliance or relationship and interactive repair becomes a prominent component used by the therapist or parent. The therapist’s use of self also is an important component in this phase. When the therapist or parent has made a mistake it is vital to treatment that adult not allow the adult’s shame to preclude the adult’s acknowledging the mistake the adult has made and the breach that results. One of the therapist’s primary responsibilities is to maintain a healing and therapeutic pace of treatment. As described elsewhere (Becker-Weidman, 2010), it is not mistakes that cause problems in treatment. It is the lack of acknowledgement and repair of those mistakes that creates problems in treatment.

Once the Alliance has been formed, the therapist acts to deepen, strengthen, and maintain the alliance. As with the other phases, this phase overlaps the other phases and the other phases cycle back to this phase. For example, Exploration that leads to Integration and Healing helps Maintain and strengthen the alliance.
The primary tasks of Maintaining the Alliance are:

- Deepening and strengthening the therapeutic alliance
- Managing emotional proximity
- Exploring initial theories of behavior: the meanings to be explored.
- Repairing relationship breaches.

Five components of Dyadic Developmental Psychotherapy are particularly salient during this phase of treatment: PACE, intersubjectivity, follow-lead-follow, interactive repair, and the co-regulation of affect. In this second phase of treatment the therapist will want to pay particular attention to using follow-lead-follow as the beginning approach into the exploration phase. How the client responds to the “lead” step of follow-lead-follow is a measure of how quickly and deeply the therapist can move into exploration and a measure of the strength and depth of the alliance. This phase of treatment takes on less importance as treatment progresses. The reason for this is that later in treatment the client has experienced the therapist’s intentions as being helpful and exploratory, integration, and healing have led to a more flexible and present-reality grounded internal working model. Later in treatment the therapist does not have to focus as much on maintaining the alliance because the alliance has greater emotional depth and strength. The client will have experienced the therapist’s intentions to be helpful and the client will have experienced the positive results of difficult explorations.

**EXPLORATION**

Exploration requires a secure base (an Alliance) and can occur within the very first meeting. Exploration requires a sense of safety (physical, emotional, and psychological) and security. There are four primary tasks during the Exploration phase. The goal is to explore history, memories, events, and experiences that continue to shape the client’s relationships and that continue to affect behavior and functioning. Primary tasks in this phase are:

- Exploring how the past is alive in the present
- Exploration of internal working models
- Exploring the meanings of events and behavior.
- Developing the reflective function.

The primary components of Dyadic Developmental Psychotherapy that are especially important in this phase are: PACE, creating and maintaining intersubjectivity, developing the reflective function, insightfulness, follow-lead-follow, interactive repair, commitment, co-creation of meaning, and the co-regulation of affect. Of these, the co-creation of meaning and the co-regulation of affect are particularly important. PACE leads to concordant intersubjectivity. Concordant intersubjectivity, interactive repair, and the reflective function help co-regulate emotions. The affective/reflective dialogue and insightfulness, along with PACE, facilitate the co-creation of meaning.
INTEGRATION

Integration occurs in a cyclic manner. Exploration leads to Integration, which allows for deeper exploration and further Integration and Healing. Integration includes neurological integration, emotional integration, and psychological integration. Its hallmark is the capacity to see shades of gray instead of absolutes. Integration is seen when a client is able to hold disparate feelings at the same time. Integration occurs repeatedly in treatment and over time. In many regards it is a developmental process in which experiences, memories, events, relationships, emotions, and one’s autobiographical narrative are reworked in a flexible manner. Many mental health difficulties can be viewed as representing a lack of integration. For example, the flash-backs associated with Post Traumatic Stress Disorder and Complex Trauma are a function of the lack of integration of episodic and implicit memories. Many of the cognitive difficulties associated with Complex Trauma are a function of problematic neurological integration.

Integration requires that past events, situations, and experiences be reviewed and revisited (exploration) so that the internal working models can be made explicit, subject to exploration, and new meanings thereby created. It is the new meanings that represent a new integration of emotions and cognitions. It is most useful to think of integration as a process or spiral. In this view, developmental tasks run vertically, and integration is an ascending spiral that returns to each element in a deeper and deeper fashion. In this way the person achieves greater levels of integration over time (Becker-Weidman, 2010).

The primary task of Integration is the development of a coherent autobiographical narrative. Creating a coherent autobiographical narrative involves two elements: the integration of trauma and reduction of splitting off of implicit from episodic memories, and an enhanced reflective function. Within this phase the Dyadic Developmental Psychotherapy components that are most relevant are: PACE, the affective/reflective dialogue, and co-creation of meaning. During this phase, which may constitute the bulk of treatment toward the middle and end of treatment, a review of the client’s life story and a reflection on the client’s current state and how the past may still be active in the present make up a large proportion of treatment. Exploration and Integration occur in tandem and reinforce each other. Exploration leads to Integration and Integration allows for deeper Exploration.

HEALING

Healing occurs throughout treatment. Healing is not so much a separate phase as it is, in part, an outgrowth of Integration. Integration is a healing process. However, it is important to note that the development and maintenance of an alliance can be healing in and of itself. The development of an emotionally meaningful relationship is healing and can remedy some of the effects of early, chronic, maltreatment that has occurred within a care-giving relationship. The outcomes of healing include the development of a more complex, nuanced, and integrated autobiographical narrative, and a better developed reflective function. A few of the components of Dyadic Developmental Psychotherapy that may be more salient during
Healing include the following: Co-creation of new meanings, Insightfulness and reflection, affective/reflective dialogue, and PACE.

As treatment is drawing to a close, there is increased time spent reflecting on the treatment experiences and a celebration of how life is different. This is not to say that the therapist doesn’t note and comment on positive experiences in each and every session. That is often an important element of each session; the reflection on what good has occurred. This reflection on positive changes and a celebration of the long and difficult journey is an important element of beginning to end treatment and integration of the experience. This process helps frame the treatment experience and find its place in the family narrative. During this process, all the components of Dyadic Developmental Psychotherapy will be evident.

**COMPONENTS OF DYADIC DEVELOPMENTAL PSYCHOTHERAPY**

These components include:

1. Therapist use of self
2. Process focused: It’s about connections not compliance
3. PLACE and PACE (Playful, Loving, Accepting, Curious, Empathy and Playful, Accepting, Curious, Empathy)
4. Intersubjectivity
5. Reflective Capacity
6. Affective/Reflective dialogue
7. Commitment
8. Insightfulness
9. Coherent Narrative
10. Co-regulation of emotions
11. Co-creation of meaning
12. Follow-lead-follow
13. Interactive repair
14. Nonverbal-verbal dialogue

A few of the basic principles of Dyadic Developmental Psychotherapy may be summarized in the following four paragraphs.

1. Both the caregivers’ and therapist’s own attachment strategies are organized and resolved before the onset of the child’s treatment. Previous research (Tyrell *et al.* 1999; Dozier *et al.* 2001) has shown the importance of the caregivers’ and therapist’s state of mind with respect to attachment for good treatment outcomes.
2. The therapist and caregiver provide the intersubjective experiences for the child that were seldom present in situations of abuse and neglect. These intersubjective experiences are characterized by shared emotion (affect), attunement, shared awareness and attention, and complementary intentions. Intersubjective experiences are the primary means by which the infant and young child learn about self, other, and the world (Trevarthen 2001). Complex trauma will significantly disrupt the
development of concordant intersubjectivity and increase the risk that the child will be unable to create a coherent meaning for many events, particularly traumatic ones. The therapist must provide concordant intersubjective experiences for the parent that help create a secure base within which the parent, child, and therapist can co-create new and more therapeutic meanings for experiences. Whenever possible, the child’s primary caregiver (biological, adoptive, or foster parent or primary caregiver in a residential setting) is an active participant in the session. The therapist must provide to the caregiver support and guidance in communicating thoughts, emotions, and intentions to the child in a therapeutic and concordant positive intersubjective manner. The primary caregiver serves as the primary source of safety, security, and comfort while the child explores events, experiences, and emotions that may generate fear and shame. The caregiver’s presence allows the therapist to facilitate the successful exploration and resolution of behavior problems in the home by modeling for the parent PACE (Playful, Accepting, Curious, Empathic, described more fully below) as an effective means of achieving conflict resolution and increasing emotional and behavioral regulation within the home. The therapist will generally only see a child, usually a teenager, as an individual client when a primary attachment figure is not available. In these instances, the treatment will proceed at a markedly slower pace since the child is essentially emotionally alone the rest of the week in the process of integrating the therapeutic themes. The lack of a primary attachment figure is a severe impediment to creating the security and safety necessary for exploration and integration.

3. Use of PACE and PLACE. These acronyms describe the “attitude” of the therapist and caregiver. PACE refers to the therapist setting a healing pace of treatment by being playful, accepting, curious and empathic. Through PACE, the therapist is able to both generate and regulate, through empathy (and playfulness when appropriate), the emerging emotion that is associated with the events being explored. Positive concordant intersubjective experiences are largely created with PACE. The therapist is also able to facilitate an open, reflective attitude to reorganize the experience of these events through the therapist’s accepting and curious stance. PLACE refers to the parent creating a healing environment by being playful, loving, accepting, curious and empathic. All interventions are utilized within the context of PACE/PLACE along with the other principles presented in this monograph. Any technique may lead to dysregulation if these basic principles, which are needed to generate general safety, are ignored. These ideas are described in more detail in Becker-Weidman, (2010), Becker-Weidman, (2011), Becker-Weidman and Shell (2011), Becker-Weidman and Shell (2010), and Hughes (2006, 2007, 2009).

4. The inevitable misattunements and conflicts that arise in relationships are directly addressed and repaired through the ongoing qualities of the relationship using PACE; interactive repair. The creation of concordant intersubjectivity facilitates the co-creation of meaning and the co-regulation of emotions. The need for interactive repair is especially important as the themes being explored are often characterized by shame and fear. Repair helps with both affect and behavioral regulation. Repair directly addresses the child’s convictions, based on past negative experiences of neglect and abuse, that the child must face stressful events alone or that any conflict will lead to abandonment. The attachment figures are responsible for the initiation of
repair, not the child. These same principles apply to the therapist-caregiver relationship. Inevitable misattunements between therapist and parent are directly addressed and repaired thought the relationship. It is the therapist’s responsibility to initiate the repair, not the parent.

**THERAPIST USE OF SELF**

A carpenter uses levels, saws, nails, and hammers. The Dyadic Developmental Psychotherapist uses self. Use of self by the therapist is at the core of how Dyadic Developmental Psychotherapy is implemented. Use of self involves the creation and maintenance of concordant intersubjective experiences; the sharing of one’s experiences of the other in a therapeutic manner. This use of self is always focused on helping the client achieve greater self-knowledge, more flexible modes of relating, and more authentic emotional experiences that reflect the nature and quality of the current relationship. All the other components of Dyadic Developmental Psychotherapy are enacted through the therapist’s use of self. PACE is largely a function of the therapist’s use of self in a therapeutic manner. The therapeutic use of self requires a well-developed reflective function and secure state of mind with respect to attachment. As the therapist creates concordant intersubjective experiences, the therapist monitors the effect on the other and the other’s emotional experience. The goal is to create emotionally meaningful experiences that facilitate the integration of memories and emotions that were dissociated (split off) as the result of early relational trauma. The therapist must constantly monitor the other’s affective state to keep the interactions emotionally meaningful and not dysregulating (Becker-Weidman, Ehrmann, LeBow, 2012). The therapist’s use of self involves keeping up an affective/reflective dialogue among family members. By reflecting on and monitoring the immediately occurring experiences, the therapist keeps a balance between the affective and the reflective elements of the dialogue. The therapeutic use of self as described here is what allows for the creation of a new and coherent autobiographical narrative, the co-regulation of emotions, and the co-creation of new meanings. Much of this occurs on a non-verbal level through the use of tone of voice, volume, gestures, cadence, expressions, and modulation of voice: the verbal-non-verbal dialogue. In order to help the client explore potentially painful and disturbing memories, emotions, and experiences, the therapist consciously follows the client (through acceptance and curiosity), then leads the client deeper, and again follows at this deeper level. Finally, when inevitable misunderstandings arise, the therapist must be able to manage the experience of shame so that the therapist can accept responsibility for the therapist’s mistake. By acknowledging one’s errors, mistakes, and misjudgments, the first steps toward interactive repair can occur. In this manner the therapist models with the caregiver how the caregiver can respond to the child when there is a breach in that relationship.

To effectively and therapeutically use self, the therapist must have a relatively secure state of mind with respect to attachment, reasonably developed reflective abilities, good self-awareness, and be tolerant of ambiguity. A secure state of mind with respect to attachment has been found to be important in therapeutic work (Tyrell, et. al., 1999). A secure state of mind with respect to attachment allows the therapist to experience a range of emotions and to reflect on these emotions in a relatively unbiased manner. Self-knowledge involves being
aware of personal biases and being able to reflect on internal states. The therapist must be aware of to what extent what experiences reflect the current interactions with the other and to what extent the experiences reflect personal past history being evoked by the current interactions. Finally, tolerance for ambiguity is an important element for use of self because being tolerant of ambiguity allows the therapist not to jump prematurely to conclusions regarding what the other is experiencing and the meaning the other ascribes to the experiences. This suspension of certainty allows the therapist to form various hypotheses regarding the meaning of experiences while keeping an open mind, so that the therapist’s curiosity can emerge in an authentic and emotionally meaningful manner. Uncertainty promotes curiosity and questions with an emotional tone that reflect genuine interest in and acceptance of the other’s thoughts, feelings, meanings, and experiences. Finally, ongoing consultation can be a significant aid in this work. Consultation can support the therapist in exploring the therapist’s own experiences and use of self.

**IT’S ABOUT CONNECTIONS not COMPLIANCE**

Relationships (friendly, intimate, therapeutic, etc.) are built on connections or experiences that have emotional valance and value. The Dyadic Developmental Psychotherapy therapist focuses primarily on relationships and connections, not compliance. It is not that compliance is not important; it is. It is that the way to secure genuine and authentic compliance is through connections and relationships. This is an important concept for caregivers to integrate into their parenting. It is through connections that the child will internalize the parent’s “voice” and develop impulse control, morals, values, and more positive social functioning. The story of Pinocchio, in some respects illustrates this. As long as Jiminy Cricket was on Pinocchio’s shoulder, Pinocchio was well behaved. But whenever Jiminy Cricket was away, that was when Pinocchio got into trouble; he’d not internalized “compliance.” At the end of the story Pinocchio becomes a “real” boy when he goes off to save his father Gippetto. In other words, Pinocchio I becomes a real boy when he cares about another.

**PACE and PLACE**

PACE is the attitude of the therapist. It is the therapist’s responsibility to maintain a healing pace of treatment. It is an acronym for being Playful, Accepting, Curious, and Empathic. PLACE is the attitude of the caregiver. It is the caregiver’s responsibility to maintain a healing place. It is an acronym for being Playful, Loving, Accepting, Curious, and Empathic. It forms the core of how the therapist or parent begins to explore an event or issue. PACE is also the primary means of initiating “interactive repair” (described below) during the session. This is required whenever the child initiates a break in the relationship or the break is created by a misattuned initiative or response by the therapist or parent.
INTERSUBJECTIVITY

As previously described, intersubjectivity is shared affect, intention, and attention. Intersubjectivity can be concordant, when all three elements are in accord, or it can be discordant. When an interchange seems to be going awry, it is useful to consider which element of the intersubjective experience is discordant. Very often it will be that the intentions are discordant. An example may serve to illustrate this. In this example, the therapist is talking with a single parent, Steve, about his son, Eric, age thirteen. Steve appears to be rather critical and punitive, and the therapist wants to help Steve focus on what is driving Eric’s behavior rather than on surface behavior. However, in this example, the interchange does not go well.

Steve: I just got Eric’s five week report and it is awful. He’s failing math and Science and is barely passing his other subjects. I told him if he doesn’t do better, he’d be grounded until he does. I am so mad at him.

Therapist: OK, so you want him to get better grades. Why did he do so poorly? (Problem solving rather than looking deeper)

D: Because he doesn’t study and missed a lot of homework.

T: I see, so you figure you can get him to study more and do his homework if he’s grounded and has no TV or computer or games?

D: Exactly!

T: You’ve done this before, and it hasn’t worked. Why do you think it will this time? (Problem solving. The therapist is now beginning to feel annoyed with Steve not getting what they’ve talked about before)

D: What else should I do? (Steve starts to become defensive; no surprise)

T: I think you have to understand that the way to get him to do well is by having a better relationship with him. “It’s about connections not compliance,” is what I say. (This problem solving intellectualized statement has a strong undertone of blame. Perhaps the therapist is feeling that he has to defend Eric. This is where the therapist could have moved the interchange into a concordant intersubjective experience.)

D: What, so I’m supposed to be his buddy and ignore his bad grades?

(And now, Steve and the therapist are on opposite sides of the fence and are arguing. They are not engaged with each other in a concordant manner.)

T: No. What I mean is the way to get good grades is to focus on having a relationship with him so that he wants to do well. Right now he feels you are forcing him to do well. (Here the therapist is beginning to act as Eric’s advocate, defending him against his father).

D: So what’s wrong with that?

T: What’s wrong with that is that now you are both in a control battle with Eric’s grades. Privileges being the ammunition, you each are shooting at each other. (And the therapist is in a control battle of sorts with the father).

It goes downhill from here. While what the therapist is saying may be on target, the interchange is not concordant on the dimensions of intention or emotion. The therapist appears to be set on “explaining” what Steve should do, and Steve appears to be set on defending his approach. They don’t have joint shared intention. It is also likely that Steve may be feeling blamed by the therapist and that the therapist may be feeling annoyed that Steve just doesn’t “get it.” Maybe the therapist is thinking, “Eric is a good kid, if only Steve
would see that.” So the therapist begins to try to act as Eric’s advocate and defender. This may then lead to an interpersonal conflict between the therapist and Steve when the conflict between caring about Eric and wanting to have him get good grades should be intrapersonal (within Steve).

The following example illustrates how focusing on the elements of intersubjectivity and what is discordant can lead to a more effective interchange.

Steve: I just got Eric’s five week report and it is awful. He’s failing math and ELA and is barely passing his other subjects. I told him if he doesn’t do better he’d be grounded until he does. I am so mad at him.

Therapist: You sound upset. (The therapist moves to affect)

D: You bet I am. I know he can do better; he’s just lazy!

(Now, the therapist could argue with Steve about whether or not Eric is lazy or if he just feels so bad about himself that he acts in a way to confirm his self-image, or maybe that Eric’s past experiences have led him to feel nothing he does matters, so why try? However, instead the therapist will stay focused on Steve for now to deepen their concordant intersubjectivity and keep all three dimensions in sync.)

T: You sound disappointed or hurt, maybe that Eric isn’t doing better.

D: I am disappointed. I know he can do better; he’s a smart kid. He could have a great future if he applied himself. (Steve is now talking more softly, and he appears more somber).

T: You really love Eric and want him to do well, don’t you?

D: Yes, I’m his Dad. I’ve been trying for four years now, and I just get so frustrated sometimes that nothing I do makes a difference. What am I going to do?

T: Let’s figure it together, OK? I’m sure we can come up with something.

D: OK

T: You said Eric is a bright kid and could do so much better. What is your guess on why he doesn’t? (The therapist has now created joint intention and attention: “we will figure this out together).

D: I just think he’s lazy.

T: Education is really important to you, and you’ve said that he could go far with his brains, so what would make such a kid be lazy? (Here the therapist accepts Steve’s view and tries to go deeper by asking a question, by being curious.).

D: Maybe he never had anyone teach him how to work?

T: You mean that maybe, because he was so neglected as a young child, he never learned to put forth effort and all those foster homes he was in never made him feel anything mattered or that he mattered?

D: I never thought about it that way, but yea, that makes sense, the poor kid. So what do I do now?

T: Well, let’s figure out how to help him feel he’s capable and see what you see in him.

D: Well, punishing him like I’ve been doing doesn’t work. All it probably did, I now see, is confirm that he’s a failure and that I’m mad at him. How do I make that up to him? (Because of the safety created by the therapist, Steve is able to explore what he’s been doing and consider alternatives.)

Within this concordant intersubjective experience, Steve and the therapist have achieved two things. First, they have deepened their relationship. The therapist understands Steve better, and Steve feels the therapist wants to help him by understanding him. The therapist has modeled with Steve what the therapist may want Steve to do with Eric. Second, they co-
created a new meaning for Eric’s poor grades that leads to a different and more effective set of behaviors.

**Reflective Capacity**

Reflective capacity refers to the capacity to simultaneously be in an experience and to be able to think about that experience. Peter Fonogy (Fonogy, et. al. 2002) describes this as mentalizing.

It means having a mental representation of self, other, and the relationship. This mental representation allows one to anticipate the other’s potential actions, feelings, and thoughts and then act accordingly.

It is the basis for empathy, the capacity to see and feel with the other. Obviously the therapist must have a well-developed reflective function. One of the goals of treatment is to enhance and develop the caregiver’s reflective capacity and to develop and enhance the child’s reflective capacity. The reflective function is necessary for impulse control.

It provides that half second of pause, so one can consider a response within the context of what one believes the other’s intention, feelings, and thoughts are.

**Affective/Reflective Dialogue**

An affective/reflective dialogue can be described as a conversation that contains emotional, reflective, and cognitive elements. It is a relaxed and meandering dialogue that has a story-telling quality to it. In many ways the affective/reflective dialogue describes the ebb and flow of a conversation in which there is an experience with emotional valance and then some reflection about the experience. There is emotional engagement in this dialogue. This relaxed and meandering dialogue often side-steps resistance since the client is an active participant in the dialogue and the resulting co-creation of meaning.

**Commitment**

The therapist’s commitment is to the family; to help the family become a “happier” place. To achieve this, the therapist may find that the therapist’s primary commitment will have to be to the parents since they are the keystone for healing and a successful outcome.

Many therapists trained as child therapists find themselves in the awkward position of feeling, "If only the parents would get a grip, this child would be fine.” What then often happens is that the therapist begins to feel and act as the child’s advocate, speaking for the child and trying to convince the parents to be better parents. This path frequently leads to an impasse or to the family discontinuing treatment.

If the parents have difficulties that impair their ability to create a healing place, the therapist will have to use PACE and the affective/reflective dialogue to create a secure base that will allow the parents to explore what is interfering with their being the sort of parents they would like to be. The therapist use PACE to join with, accept, understand, and support
the parents so that the parents can accept, understand, and support their child. “Whatever the therapist wishes the parents to be able to do with their child the therapist has to be able to do with the parents.” This forms the bedrock of the therapist’s stance in regard to the primary caregivers.

**INSIGHTFULNESS**

Insightfulness is related to the reflective function described above. To be insightful means to look within, “in” “sight.” Insight involves the ability to look within and to more deeply understand one’s self, one’s motives and intentions, and how these have been shaped by past and current experiences, relationships, and events.

Insight allows the therapist to better understand what emotions are being activated by the therapist’s past experiences and which emotions are being activated by the current experiences. Developing insightfulness among family members is one of the important tasks of the therapist practicing Dyadic Developmental Psychotherapy.

The therapist accomplishes this through the use of the affective/reflective dialogue, by the co-creation of meanings, by follow-lead-follow, by interactive repair, and by the verbal/non-verbal dialogue. The affective/reflective dialogue along with the verbal/non-verbal dialogue is one method by which insight is achieved. This dialogue with its emotional and reflective components is how the client achieves greater self-knowledge. When entered into, this dialogue is how new and more helpful meanings of experiences are co-created. This dialogue is led by the therapist in the follow-lead-follow format.

Interactive repair ensures that the inevitable mistakes that occur in this process are owned and accepted and then explored and repaired. It is within the safety of the secure base that the exploration necessary to achieve integration and healing can occur. This integration and healing occurs by exploring current experiences and their connections to past experiences. By exploring how the past is alive in the present, the therapist assists the client in achieving deeper insightfulness.

**COHERENT NARRATIVE AND THE CO-CREATION OF MEANING**

The creation of a coherent autobiographical narrative is one marker of mental health. A personal narrative changes over time, and it is this narrative that gives meaning to one’s life and experiences. Those with a secure pattern of attachment are able to tell a coherent story about their life, regardless of how difficult that life may have been. A coherent autobiographical narrative reflects the integration of the left brain hemisphere function of containing explicit memories with right hemisphere where affect and implicit memories are located. Trauma interferes with this integration. Without this integration, one’s sense of self with a past, present and future can become distorted, vague, and disconnected. Clients who have experienced complex trauma frequently have disjointed, split-off, and dissociated autobiographical narratives. The episodic and emotional elements of the trauma are split off and disconnected from each other. While the emotional sequelae of the trauma are clearly evident in the person’s behavior, the person is not aware of this. Revisiting the trauma in detail and in a titrated manner so that the emotions are experienced in the safe and secure setting of the therapy session and in the family allows for the integration of emotional and
episodic memories and the conscious awareness of how these events and feelings are operating in the present. It is this insightfulness that provides an important healing dimension to treatment. Once dissociated elements are integrated into a coherent autobiographical narrative, the client is able to manage the underlying emotions and engage the reflective function to select an appropriate and self-advancing response.

**CO-REGULATION OF EMOTIONS**

Children and adults with difficult histories often have not received the necessary experiences that would allow them to effectively regulate their own emotions. In most typical circumstances, a parent first regulates the infant’s emotional world and so regulates the infant’s emotional experiences. The “good enough” parent provides stimulation to activate the infant but is careful not to over-stimulate. The “good enough” parent soothes the upset infant and reduces distress. In this fashion, the parent regulates the infant and young child’s level of arousal and emotional experiences. Over time the child begins to internalize this shared co-regulation of affect and becomes self-regulating. The sequence is first the parent regulates the child, then the child is able to achieve emotional regulation with the parent’s help, and then the child can self-regulate.

**FOLLOW-LEAD-FOLLOW**

Follow-Lead-Follow describes the ebb and flow of the dialogue within the Dyadic Developmental Psychotherapy session. This framework is designed to encourage client engagement and to increase the client’s sense of safety, security, and personal control. The therapist begins by using the PACE framework, accepting what the client says. The therapist follows the client’s flow of dialogue and emotion and stays in step with the client. The objective here is to, metaphorically, walk with and next to the client. This helps create a secure base by providing the client with acceptance and a concordant intersubjective experience. Client and therapist are sharing affect and are attending to the same thing. Intentions are conjoint and complimentary, so the therapist is interested in what the client is interested in at the moment. The client will feel valued because the therapist is focusing on what the client finds of interest. Once the dialogue has moved along to some degree, the therapist can then begin to lead the client into a related path that has a different trajectory. For example, the therapist may begin to note how this situation is similar to one that occurred in the past or comment on what the client may have been feeling. The therapist leads the discussion deeper. Once on this new trajectory, the therapist again follows the client and the cycle continues.

**INTERACTIVE REPAIR**

Interactive repair (Tronick 1989, Tronick 2005) describes how the therapist or parent responds to the inevitable breaches that occur in any relationship during the ebb and flow of
Interactive repair refers to the caregiver’s (or therapist’s) actions to repair the relationship and to emotionally reconnect with and reestablish an attuned relationship with the child (or parent) after there has been a breach in the relationship. Interactive repair is the process by which a caregiver repairs some misattunement in the relationship in a manner that reduces shame. Interactive repair leads to the development of greater capacity to experience negative emotions without resultant shame and dysregulation. Interactive repair requires a caregiver who is sensitive and collaborative. When the caregiver helps the child recover from a negative affective state, the amount of shame experienced is reduced. When the caregiver engages in interactive repair on a fairly consistent basis, the child develops an internal experience of self as effective, that the child’s intentions are positive, and that distress is repairable. These same effects of interactive repair apply when it is the therapist who initiates interactive repair with a caregiver. This models for the caregiver how to engage in this most vital process.

The healing dimension of interactive repair is that it reduces shame. Interactive repair can help a child progress developmentally from a shame-based identity to the experience of healthy and appropriate guilt. The parent setting a limit may cause the break in the relationship, specifically in some element of shared intersubjectivity, usually a discontinuity in shared emotion or joint complementary intention. A breach in the relationship can also be caused by an adult misunderstanding the child or missing important emotional cues. The disruption in the relationship that occurs may lead to the child experiencing shame. The cycle of experiencing positive affect following negative experiences teaches the child that negative emotions can be tolerated and resolved and that the relationship can be repaired. Over time as the healthy parent reestablishes attunement, the child begins to experience the self as intrinsically good, although as one who occasionally does “bad” things. It is this movement from feeling that one is bad to feeling that one is good but does bad things that is at the core of the developmental step from shame to guilt.

**Practice in Residential Treatment Settings**

Dyadic Developmental Psychotherapy can be used effectively within residential treatment, group home, and other congregate care settings. Clearly all the elements discussed in this monograph can be used with children in foster care; the foster parents are the primary caregivers. In residential treatment settings, the child care staff function as either co-parents with the child’s parents or as the primary caregiver. When practicing this approach in residential treatment settings, the therapist will involve the care staff with the child in treatment, to the extent that this is possible. The more closely the care staff function as primary caregivers the more effectively can the underlying trauma and attachment disturbances be resolved. All of the components and principles of treatment described in this monograph can be integrated into the milieu of the residential care facility. However, it is important to recognize that a program using an attachment model of care operates differently than one using a behavioral model of care. Specific training for the staff is necessary to implement such a model of care. My experience training staff in residential programs around the world is that with the proper training, these staff can become a very powerful therapeutic influence in the child’s life and the resulting change can be dramatic. The use of Dyadic
Developmental Psychotherapy in residential settings is described fully elsewhere (Blackwell & McGuill, 2011; Clark, 2011)

**SUMMARY**

This monograph has provided the reader with an overview of Dyadic Developmental Psychotherapy. This treatment has a good empirical base supporting the efficacy of the approach.

In addition, it is consistent with generally accepted standards of care (Becker-Weidman, Ehrmann, LeBow, 2012). Dyadic Developmental Psychotherapy is a family therapy model of treatment, grounded in attachment theory.

However, the general principles and components of this approach can be used in other treatment modalities as well, such as in couples treatment, individual therapy, and group therapy. In addition, the model can be used in outpatient settings, inpatient settings, residential treatment centers, and other venues. The model draws on a number of well researched and common factors in effective psychotherapy.

**REFERENCES**


