Trauma through the Life Cycle from a Strengths Perspective: An International Dialogue
Jerusalem, January 8th and 9th 2012

The Haifa Dyadic Therapy: A mentalization based treatment applied to war traumatized children

Judith Harel
Department of Psychology, Haifa University, Haifa, Israel.

Hanna Kaminer
The Clinic for Psychological and Developmental Treatment, Ministry of Health, Haifa, Israel
Haifa Dyadic Therapy model

Aims of the presentation:

• Describe the HDT model and its adaptation to war trauma
• Demonstrate the model’s application to the treatment of a child and his parents
• Show some research findings
Haifa Under Missiles Attack
Children exposed to war

For five weeks, in 2006, Israel had been plagued by war. Day and night Hezbollah bombarded Israeli civilians using hundreds of missiles and rockets. Loud sirens have preceded most of the attacks, and small children were frightened by the sirens even when not followed by missiles.

Children and adults were exposed to highly stressful and anxiety-provoking situations, and to the recruitment of many male family members to defense service.
Children exposed to war

• Children and adults who experienced these attacks were at high risk for developing PTSD.

• It is important to detect and treat this condition as early as possible given the high rate of trauma exposure in war and the long-lasting course of PTSD, (Cohen, J, 2010).
Plan of the presentation

• The Haifa Dyadic Therapy (HDT)- a mentalization-based model for pre-latency children
• What is mentalization?
• How it develops?
• HDT as a mentalization based therapy
• The disruption of mentalization in trauma
• The adaptation of the HDT to trauma treatment
• Case presentation
The HDT model

• The parent-child **relationship** is the patient

• **Relationship**- the observed and the represented

• The child has specific relations with each parent

• Parent and child are treated together: mother-child, father–child in alternating weeks

• Mother-father, every second week
Treatment Format

- Mother - Child
  Therapist

- Father - Child
  Therapist

- Mother - Father
  Therapist
The HDT model

• The model integrates an intra-psychic, object-relational view with an interpersonal perspective to treatment.

• The therapist attends to the dyad at the level of overt, interpersonal behaviors as well as at the covert level of meanings, representations, intentions, affects, memories, their minds.

• The therapist makes links between these two levels, thus facilitating the dyads’ mentalizing capacity.
The observed Interaction is the meeting ground of the Parent’s and Child’s minds.
Implicit relational knowing

It is claimed that our earliest and most important ways of being with significant others, are stored in implicit memory and become accessible only through behaviour with the specific other. (Fonagy, 2001)
Implicit vs. explicit knowledge

The active participation of each parent in the sessions with the child enable the therapist to observe and experience their implicit relations, ways of being together, which are not knowable by listening to the parents’ verbal description (explicit) of the relationship with the child.
HDT characteristics

- Active parental participation
- Fathers
- Behavior (reality) and mind (psychic reality, inner world)
- Reflective Functioning - mentalization
- Playful interactions
- Sessions are videotaped for supervision
- Implicit relational knowing
- Transference: Parent ↔ Child ↔ Therapist
Changing aims in psychoanalytic psychotherapy

From - Children whose problems stem from conflicts between representations

To - Children whose problems stem from difficulties in the processes of creating representations

The HDT is aimed at children and parents who show difficulties in processes of creating representations – difficulties in mentalization
Some potential sources of difficulties in Parent-Child relations

Inhibited mental processes: no mentalizing, responding in behavioral terms

Parent

I must stop this!
Mentalizing

- The capacity to mentalize is the capacity to see the self and the other as having a “mind”,
- Mind = an inner world of thoughts, emotions, intentions, memories etc. which direct behavior
- Mentalizing is the capacity to think about thoughts, emotions, realizing that they are not equivalent to reality
- Regarding self and other as having a mind results in coherent representations, gives meaning to behaviors, helps in affect regulation and enables prediction of behaviors
Mentalizing in Parent-Child relations

Parent: I wonder why are you crying?
Child: I am sad, I lost my teddy.
Mentalizing is not an “all or non” function

- There are **individual differences** in mentalizing capacity
- A person’s mentalizing capacity depends on the interaction **partner** (mother/father/therapist)
- A person’s mentalizing capacity depends on the interaction **theme**
The development of mentalization

• Mentalization develops in a **dyadic process** of affect reflection, in which the parent reflects the affect of the child (Gergely & Watson, 1996).

• Two features of the process are critical:
  – **Contingency** - the parent reflects the child’s exact affect.
  – **Markedness** - the parent’s reflection of the child’s affect is modified, either by mixing with other affects, or by exaggeration, thus enabling the child to discriminate his affect from that of the parent.

• In the process the child internalizes a **re-presentation** of his affect, and gradually develops a representational system of mental states.
Playing with reality

• The link between reality and fantasy (mind, psychic reality) is experienced in different modes:
  ▶ **psychic equivalence, actual mode** - fantasy/thought and reality are the same
  ▶ **pretend mode** - fantasy and reality are strictly kept apart, so that the fantasy can continue, and
  ▶ **mentalizing mode** - reality and fantasy are linked but are not the same

• These modes are observable in **play**, in language, in behavior
Play

- **Play** is natural and ubiquitous for pre-latency children, for whom the HDT is an optimal form of treatment.

- After infancy **play** is the optimal context for mentalizing: inner world expressed in reality, expressed in the interaction.

- Therapist encourages the child and the parent to reflect on the play.
Relationships and mentalizing

- Mentalizing develops in a secure relationship (secure attachment).
- A child has a mind provided that the parent regards it as having a mind.
- Children showing problems in mentalizing tend to have parents with similar problems.
- Improving the relationship creates the context for improved mentalizing.
HDT as a mentalization based therapy

- Enhancing mentalization is the goal and the means of the therapy model

- Mentalizing is facilitated in the dyadic relationships which are the focus of the therapy:
  - mother-child,
  - father-child,
  - mother-father
Promoting mentalization

• Creating a secure base for parents and child, to enable the exploration of the inner and actual world (secure attachment related to mentalization)

• The therapist employs a mentalizing stance

• The participants identify and internalize mentalizing skills
I think, therefore I am ...

- **Mother-child session** - Mother thinks I am ...
- **Father-child session** - Father thinks I am ...
- **Mother-father session** - Therapist thinks I am ...

Therefore I am ...
Therapist’s stance in mentalizing therapy

Compared to more “classic” models, the HDT therapist is:

• more open - “I wonder what to say now”
• less neutral - “I think I would feel the same as you did”
• more actively cooperative - “let’s try to understand this”
• takes responsibility for empathic failures - "I am afraid I have confused you"
Trauma and mentalization
Trauma disrupts mentalization

• Following trauma, mentalization is disrupted and earlier forms of relating reality to fantasy reemerge:
  • Psychic equivalence - seen in trauma as flashbacks
  • Pretend mode- seen in traumatic dissociation
Trauma disrupts play

• The inability to play- psychic-equivalence mode

• Traumatic “play”- play detached from reality, “pretend mode”
The disruption of mentalization in traumatic situations is defensive

• In war it may be too painful and anxiety provoking to imagine the enemy’s intentions and emotions.

• Disrupting mentalization is reducing inner conflicts regarding one’s own hostile feelings (Fonagy and Target, 2003).

• Since it is defensive it can be restored in therapy
The aim of trauma treatment

The restoration of mentalization
The attachment system is activated in situations of stress not only to ensure the child’s proximity to the caregiver (Bowlby, 1969) but also to enable the child to restore mentalization with the help of the parent-child relationship (Fonagy and Target, 2003).

When parent and child are both affected, as in war situations, they both need to restore their mentalizing capacities.
HDT and trauma

Therefore the HDT as a model for treating parent and child together and regarding mentalization as the goal of therapy - is specifically suited for parents and children following trauma.
Active parental participation

Important in trauma because the setting enables the therapist to:

• Restore the parent as protector of the child in the interaction and in the parent’s and the child’s mind

• To diminish parental avoidance of reminders of the trauma, enabling the child to expose the trauma

• To enhance mentalization as a skill.
The adaptation of the HDT to trauma treatment

Two modules were added to the original model:

• Exposure of the traumatic event

• Constructing the narrative
Exposing the trauma in play

• “If one could live a thousand years, one might completely work through a childhood trauma by **playing out** the terrifying scenario until it is no longer terrified.” (Terr, 1991, pp13).

• This quote points to the importance of exposing the trauma and **playing it out** in the sessions. It also points to the difficulty of doing so.
Exposure of the traumatic event

Parents tend to avoid reminders of the trauma:

• In order to protect the child
• Because they are traumatized themselves,

Thus they hamper the child’s attempts to expose the trauma

video
Decreasing the avoidance

• The secure ambiance created by the therapist, and the presence of the parent enable the therapist to help the parent to cope with and decrease the avoidance in the interaction with the child.

• The dyad identifies and internalizes the therapist's mentalizing stance and applies it in additional situations
Propositions of the AACAP for empirically proved efficient therapies for children with post trauma symptoms

- Include the parents
- Directly address the traumatic event
- Not only symptom focused

(Cohen, 2010)
The HDT suits the AACAP recommendations

The HDT model seems most appropriate for the treatment of PTSD in children:

• The model includes the parents in the child’s therapy process as active participants and agents of change

• It directly addresses the traumatic event

• It is not only symptom focused but emphasizes the enhancement of mentalization as a therapeutic factor as well as an important adaptive function for the participants’ future development.
Research

HDT applied to children and parents traumatized by war
Following the 2006 war in Israel

A large scale study was initiated by the Israel Center for the Treatment of Psycho-trauma.

Our study aimed to assess the effect of HDT on a sub-sample of dyads from this study by Harel, Eshel and Levin (2011).
Exposure effect was found

• 614 children and their parents were screened for PTSD and depression.

• An average of 21% of children showed PTSD symptoms, ranging
  – from 45% of children in cities which suffered daily from massive missile and rocket attacks
  – to 14% of children in cities in which attacks were more sporadic
Dyadic study

44 dyads (23 boys and 21 girls) participated in the study;

• 22 parent-child dyads with young children (25-57 months) accepted our offer and participated in therapy.

• 22 dyads served as a control group. All children showed signs of post trauma.
Assessment

• All participants were assessed before and after therapy
• Mothers were interviewed to assess the child’s PTSD symptoms (Scheeringa & Zeanah, 2001; Scheeringa et al. 1995, 2003, 2010) and completed the CBCL (Child Behavior Checklist, Achenbach, 1991).
• Mothers were assessed for depression with the CES-D (The Center for Epidemiological Studies Depression Scale) and the PDS (Post-traumatic Diagnostic Scale, Foa, Cashman, Jaycox, & Perry, 1997) for PTSD.
Therapy

• The dyadic therapy was short term and lasted an average of 13 weekly sessions.

• Results were analyzed for
  – the children’s status change from PTSD to normal
  – for number of symptoms before and after therapy on the PTSD symptoms questionnaire and the CBCL
Number of PTSD symptoms

Before

After

Treated group

Control group

47
<table>
<thead>
<tr>
<th>Untreated children</th>
<th>Treated children</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>28.6%</td>
<td>6 children</td>
<td>39.1%</td>
<td>9 children</td>
</tr>
<tr>
<td>28.6%</td>
<td>6 children</td>
<td>17.4%</td>
<td>4 children</td>
</tr>
</tbody>
</table>
Results

• No significant main effect of treatment x time was found
• Treated and untreated children showed fewer symptoms at the second assessment. The decrease in symptoms was significant only in children in the treated dyads.
• Fewer children in the treated group fitted the diagnosis for PTSD after therapy, compared to the untreated children
• These results should be interpreted with caution
Mother’s symptoms and child improvement

<table>
<thead>
<tr>
<th>Change in Child symptoms- Untreated dyads</th>
<th>Change in Child symptoms- Treated dyads</th>
<th>PTSD- mother</th>
<th>Depression-mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>-.41*</td>
<td>.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-.66***</td>
<td>.11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The mother-child relationship

• For mothers who did not take part in therapy there was a significant negative link between the levels of maternal pathology (depression and PTSD) and the change in the number of child’s symptoms: the more severe the mother’s condition the less the improvement in child symptoms over time.

• Such a relation was not found for the treated dyads; this might imply that the therapy ameliorated the mother’s pathological influence on the child through their relationship.
Future studies

• The results as a whole might be interpreted as showing that mothers found the therapy helpful for the child.
• Although the results point to this direction they were not significant, maybe due to the small sample.
• We hope not to repeat the study with a larger sample!!!
Thanks

• The late Miriam Ben-Aaron, the initiator of the original HDT
• The team of The Clinic for Psychological and Developmental Treatment, Haifa, Israel. for the adapted model
• The Israel Center for the Treatment of Psycho-trauma

Thank you!
HDT-Published books and papers


