



Dyadic Developmental Psychotherapy

Toward a Comprehensive, Trauma-Informed Treatment for Developmental Trauma Disorder

Dan Hughes, PhD

18 February 2014

Introduction

Developmental trauma disorder refers to a specific type of complex trauma that primarily focuses on the effects on a child who experiences abuse and neglect early in life at the hands of his parents or caregivers. This creates pervasive problems within the child and greatly compromises his development. These effects are summarized in a white paper report written by professionals at major child trauma centers throughout the United States (Cook, Spinazzola, et al, 2005). They suggest that developmentally traumatized children are at high risk of difficulties within seven domains of impairment. These are:

- 1.Attachment
- 2.Biology
- 3.Affect Regulation
- 4.Dissociation
- 5.Behavioral Control
- 6.Cognition
- 7.Self-Concept

While specific trauma-focused treatment may well be adequate for simple traumas, developmental trauma requires comprehensive treatment. The overwhelming evidence for the effectiveness of trauma treatment has focused on simple trauma. Evidence for effectiveness of developmental trauma is lacking. The white paper report just mentioned recommends guidelines for “best-practice” interventions to address developmental trauma. The treatment recommended focuses on six major categories of intervention that address the domains of impairment mentioned above. These are:

- Safety
- Self-Regulation
- Self-Reflection
- Traumatic Experience Integration
- Relational Engagement
- Positive Affect Enhancement

This paper proposes that the principles of effective treatment for developmental trauma might rest on the following considerations:

1. The psychological treatment of developmental trauma needs to address the six categories mentioned in the white paper report.
2. Attachment and Neuroscience research provide a body of knowledge that can guide our treatment concordant with the white paper recommendations.

3. The evidence for what works in the therapeutic relationship can also guide treatment and is concordant with both of the above.
4. Dyadic Developmental Psychotherapy is a comprehensive, trauma-informed treatment that is consistent with all three.

Safety and Attachment (The Parent-Child Relationship)

Safety is the primary theme of all attachment relationships. The infant seeks to be near her parents or other attachment figures when she is frightened or experiences basic unmet physical or psychological needs. These relationships develop over time in a very contingent manner, with the infant and parent coming to know unique features, expressions, and behaviors of each other in a way that best meets the infant's need for safety.

The parent is sensitive to the infant's expressions and then bases his responses on the specific features of each unique expression. When the infant communicates, the parent responds in what he thinks is the most sensitive manner. The infant communicates further if the parent's responses are not the best fit for the infant's perceived needs, and the parent adjusts to this misattunement. In this way the parent and infant are continuously fine-tuning their interactions. They are engaged in a 'dance of attunement' with micro-adjustments in each other's initiatives and responses based on how the other responded and took initiatives.

Alongside the provision of safety, parents provide their infants with a sense of who they are. The parents' initiatives and responses to the infant's expressions are central to her learning who she is. Her parents' experience of her, expressed within their contingent interactions, becomes the organizing principle of her experience of herself. When her parents experience and communicate love, joy, delight, and interest, she comes to experience qualities of herself as being lovable, enjoyable, delightful, and interesting. This form of self-discovering and learning is known as intersubjectivity and is considered to be a primary source of all social and emotional learning.

A child with developmental trauma crucially missed out on these essential experiences of a secure attachment and intersubjectivity in their relationships with their parents. For the treatment of developmental trauma to have the greatest benefit for the child, it needs to facilitate the child's ability to gain these experiences that were lacking in his early years.

2. The Therapeutic Relationship

If treatment is to enable the child to begin to develop and respond to the relational experiences that she missed in her early years, it is the therapeutic relationship that is best suited to facilitate this process.

At the same time, the central features of the child's early attachment and intersubjective experiences are congruent with what are considered to be the key ingredients of the most effective therapeutic relationship.

There is overwhelming evidence that the therapeutic relationship is central to treatment effectiveness. The findings of the American Psychological Association's 2nd Task Force on Evidence-Based Therapy Relationships are presented in two issues of *Psychotherapy* (2011 a,b), the official journal of the Division of Psychotherapy of the American Psychological Association.

This Task Force concludes in part (Norcross & Wampold, 2011, p. 98):

1. The therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment.
2. The therapy relationship accounts for why clients improve (or fail to improve) at least as much as the particular treatment method.
3. Efforts to promulgate best practices or evidence-based practices (EBPs) without including the relationship are seriously incomplete and potentially misleading.

The same Task Force summarized the central components of an effective therapeutic relationship. The first component consists in establishing a therapeutic alliance. This involves developing a collaborative commitment to the joint goals of treatment as well as the therapist developing his competence in alliance building skills. The other skills that are central in effective therapeutic relationships involve empathy, positive regard for the client, congruence or genuineness, and the ability to repair alliance ruptures.

The therapeutic relationship is even more important for children who have experienced trauma in their primary attachment relationship. For these children, it is crucial that the therapeutic relationship provides safety in order to address the traumatic events that have created developmental trauma. It is also crucial that the relationship offers new learning about the worth of the self, since the shame associated with parental abuse and neglect will have undermined any sense of worth. A therapeutic relationship that is modeled on the principles of attachment and intersubjective relationships is likely to be a good foundation for meeting the therapeutic needs of these children.

3. Support from Neuroscience

Increasingly over the past twenty years, advances in neuroscience have given us insight into the structure and functioning of the human brain. This new knowledge gives us clues as to possible ways to become engaged with the child who experiences developmental trauma so that he may begin to resolve and integrate the traumatic events and then proceed with his normal development.

Dan Siegel (2012) and Alan Schore (2001) have developed a field of study known as Interpersonal Neurobiology that helps us to understand how the human brain is designed for relationships. Within a relationship, the brain is able to function in a more integrative and restorative manner, relying on a trusted other to help to make sense of highly stressful events in order to reduce their impact on one's life.

Stephen Porges (2012) describes regions of the brain that make up the Social Engagement System. This allows individuals to learn about themselves and others. This System is activated when a person experiences safety and this sense of safety is enhanced when the individual feels accepted by the other person. With safety and acceptance, an individual is more receptive to learning from the other person. He learns who he is as well as how best to manage the events of his life. When the therapist and caregiver are able to establish safety and acceptance, the child is less likely to become defensive. He is more likely to become open and engaged with the adult and allow her to have a positive influence on him and his development.

Finally, Jim Coan (2010) has developed the social baseline theory of neuropsychological functioning. He also has found that the human brain functions in a much more integrative manner and manages stress significantly better when in the presence of someone with whom the individual is securely attached.

The findings of neuroscience overwhelmingly demonstrate the importance of a few key relationships in the young child's development in all areas of his functioning. These relationships, if they are to be effective, need to provide the child with continuing experiences of safety and new learning about self, other, and the world.

Developmental trauma occurred within a relationship that impaired the structure and functioning of the young child's brain. New relationships that enable the child to heal and restore the neurological skills that she needs to develop well are central to her successful treatment and her life.

4. Becoming Ready to Address the Trauma

It is now necessary to take the findings of attachment, neuroscience, and effective therapeutic relationships and consider what an effective treatment for developmental trauma would look like. How might it work?

The sensitive and responsive therapist and caregiver need to engage with the child in an open and relaxed dialogue. This communicates empathy and acceptance. This is likely to be of great value in creating the safety needed for the child to begin to address the impact of the traumatic events. The therapist and caregiver, communicate—nonverbally and verbally—their experience of the child's worth, strengths, courage, desire for a good life and caring qualities for others.

This is likely to be crucial for the child to re-experience his sense of self and others. This will enable the child to discover a world that he is able to thrive in, no longer defined by the traumatic events of his past.

This communication does not consist in simply telling the child that he is good, safe, and did not deserve to be traumatized. Rather it involves involving a child in a dialogue--much like story-telling--in which new meanings of the child's life-story, including the trauma, are being jointly developed through the impact they are having on the parent and therapist--and child.

These therapeutic communications are consistent with central features of the dialogue that occurs between the parent and infant or toddler. Such dialogue conveys both safety and new learning for the very young child, enabling the parent to have such a central positive impact on her child's development (Trevarthen, 2001).

5. Dyadic Developmental Psychotherapy: One Model Attempting to Integrate the Above

Over the past twenty years, Dyadic Developmental Psychotherapy (DDP) has developed as a model of treatment for children with Developmental Trauma Disorder and their families.

DDP strives to facilitate the child's relationship with her parent and therapist through developing and maintaining an affective-reflective (a-r) dialogue that generates safety while she explores all aspects of her life along with the traumatic events. The therapist and caregiver's intersubjective experience of the child and the traumatic events are clearly different from the perpetrator's meaning that was forced on the child. They serve as the bases for new meanings that are able to be integrated into child's autobiographical narrative so that it might become more coherent. This dialogue has the qualities of story-telling with voice modulations and rhythms rather than rather a rational tone that provides explanations and directives.

The relational attitude that the therapist and caregiver adopt is characterized by playfulness, acceptance, curiosity, and empathy (PACE). These features are core characteristics of a parent's attitude toward her infant. Acceptance, along with the others, facilitates the open and engaged state of mind recommended by Stephen Porges in order to have the best influence on a child.

Within PACE the therapist and parent deepen the therapeutic alliance through their genuineness as they convey their intersubjective experience of the child, his strengths and vulnerabilities.

PACE also facilitates the therapeutic alliance by emphasizing the reciprocal nature of the relationship, along with empathy and positive regard (acceptance and nonjudgmental curiosity). PACE helps the therapist and caregiver to create safety through the joint development of the child's narrative within the dialogue by maintaining an attuned interaction (known in DDP as follow-lead-follow). This attuned relationship stresses the need for the therapist and caregiver to continuously repair the therapeutic alliance while gently initiating exploration of difficult themes and respectfully moving away from these themes when the child signals "enough".

Since children who have experienced developmental trauma often are not able to communicate their inner life well they have difficulty finding the words necessary for them to become engaged in the A-R dialogue in order to develop new meanings for their life stories. They are "at a loss for words". The therapist often takes the lead in speaking for the child or speaking about him within the attitude of PACE. Such therapeutic initiatives are presented as guesses rather than interpretations or facts and the child determines whether or not they reflect her inner life.

The A-R Dialogue and PACE serve as a foundation for approaching all six of the characteristics of effective treatment for developmental trauma mentioned in the White Paper report. Safety is insured and co-regulation and co-reflection facilitate the development of self-regulation and self-reflection. The traumatic events become integrated in the child's narrative within the curious and empathic flow of the dialogue. Acceptance is highlighted for relational engagement and playfulness is highlighted for positive affect enhancement.

Finally, in DDP, the child's caregivers are present and actively involved in the treatment in order to best facilitate the child's relationship with those with whom she needs to develop a secure attachment and positive intersubjective experiences. The therapist insures that the parents' own attachment histories are resolved so that they are able to remain emotionally strong and present while assisting their child in resolving the traumatic events from their past. Once the caregiver is safe in the session, the therapist and caregiver--together--provide safety for the child.

Dyadic Developmental Psychotherapy now has a certification program for Practitioners, Consultants, and Trainers and there are certified practitioners in DDP in the US, UK, Canada, Australia, Finland, and the Czech Republic. Initial efforts are being made to establish a foundation of practice-based evidence for DDP and there is a grant proposal for research into the effectiveness of DDP at a UK University.

6. Developing the Evidence for our Effectiveness

There are clear challenges to developing evidence for the effectiveness of the treatment of children with Developmental Trauma Disorder, including DDP (Pearce & Pezzot-Pearce, 2007).

These include:

- A. Most treatment evidence is based on the treatment of simple traumas and children with one diagnosis. The pervasive symptoms of children with Developmental Trauma Disorder have caused them to be seldom studied in treatment effectiveness research.
- B. The therapeutic relationship requires frequent modifications of treatment interventions and goals if the treatment is to be a process developed jointly by the therapist and child—something crucial if the therapeutic relationship is to be of greatest value.
- C. Clinicians see value in individualizing the treatment for each unique child and family. To practice an “evidence-based” treatment requires instead that a treatment package is followed without deviation in order for the treatment to be standardized. This may make for good research while compromising the best treatment approach for the individual client.

As a result of these difficulties, developing evidence for the successful treatment of children with Developmental Trauma Disorder is likely to require information from a wide range of measures. These include:

- A. Single-case Studies. These involve more detailed measures and specialized statistical analysis
- B. Practice-Based Evidence. The therapist or specific program does a careful analysis with pre and post measures of their own clients. Comparing the results of various “real-world” programs may provide a measure of treatment effectiveness that could be compared with results obtained in university settings.
- C. A program might present the theoretical bases that serve as the rationale for their specific interventions. Specific research from the fields of attachment, trauma, child development, neuroscience, etc. might be used to establish the “face validity” for a given treatment that is being used.

DDP is a treatment model that attempts to integrate findings from the fields of attachment, trauma, interpersonal neuroscience, and therapeutic relationships into a comprehensive treatment approach for children who have experienced developmental trauma and their families. These populations are at high risk for ongoing mental health problems and family break down unless they receive the most appropriate treatment in a timely manner. Continuing efforts are being made to establish DDP as such a treatment.

References

Coan, J.A. (2010). Adult attachments and the brain. *J. of Social and Personal Relationships*, 27, 210-218.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Lautaud, J., Mallah, K., Olafson, E. & van der Kolk, B. Complex trauma in children and adolescents. *Psychiatric Annals*, 2005, 390-398.

Evidence-based psychotherapy relationships (2011a). *Psychotherapy*, 48, 4-102

Evidence-based psychotherapy relationships II (2011b). *Psychotherapy*, 48, 315-419.

Hughes, D. (2011). Attachment-focused family therapy workbook. New York: Norton.

Norcross, J.C. & Wampold B.E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy*, 48, 98-102.

Pearce, J.W. & Pezzot-Pearce, T.D. (2007). Psychotherapy of abused and neglected children. 2nd Ed. New York: Guilford Press.

Porges, S. (2011). The polyvagal theory. New York: W.W.Norton

Schore, A.N. (2001) Effects of a secure attachment on right brain development, affect regulation, and infant mental health. *Infant mental health journal*, 22,7-67.

Siegel, D.J. (2012). The developing mind 2nd Ed. New York: Guilford.

Trevarthen, C. (2001). Intrinsic motives for companionship in understanding: their origin, development, and significance for infant mental health. *Infant Mental health journal*, 22, 95-131.

I wish to thank both Kim Golding and Julie Hudson for their suggestions after reviewing an earlier draft of this paper.

Dan Hughes, PhD

8 February 2014



About DDP Network

DDP Network is a worldwide body that promotes DDP and supports professionals, parents and caregivers in finding out about the therapy and the parenting approach. We provide information about the therapy, how to become certified in DDP, the parenting approach, resources, training courses and conferences.

Contact

Web: ddpnetwork.org

Email: contact@ddpnetwork.org
