'Examining Dyadic Developmental Psychotherapy as a treatment for adopted and foster children: A review of research and theory'

The Dyadic Developmental Psychotherapy Institute (DDPI) Board members make the following statement in response to an article written by Dr Jean Mercer and published in Research on Social Work Practice, 2014. Vol. 24(6) 715-724.

Within this article Dr Mercer reviews existing research outcomes for DDP and provides a critical discussion of the theory and practice of DDP. Whilst Dr Mercer provides a comprehensive reference list of the books written by Dan Hughes, the majority of her review appears to be based on a narrow selection of literature about DDP, in particular the writings of Dr Art Becker-Weidman. She has not reviewed the many chapters and papers written by Dan Hughes. Neither did she have access to more recent papers published since her review was written (Hughes, 2014; Casswell et al, 2014). This is unfortunate as Dr Becker-Weidman has separated from the DDP Institute to form his own institute and his work has little influence on the current practice of DDP in the US and is virtually unknown in the UK.

We do not recognise the description of DDP within Dr Mercer's article and believe that her review is based on a number of misunderstandings both about the theory and practice of DDP which has led to a number of inaccuracies or incomplete descriptions of DDP. We are preparing a detailed response to this paper but feel that DDP has been so seriously misrepresented within the article that this brief response is also needed which we can have more immediately available.

The development of DDP

- Dr Mercer is accurate in describing DDP as an intervention for foster and adoptive children and their families.
- Dr Mercer is inaccurate in describing this intervention as being developed by Dan Hughes and Arthur Becker-Weidman. DDP was actually developed by Dan Hughes many years before Arthur Becker-Weidman became a student of his.

The practice of DDP

Dr Mercer states that DDP focuses on children with Reactive Attachment Disorder (RAD) and other emotional problems, and more recently Developmental Trauma Disorder.

- The diagnosis of RAD only describes a very small minority of children with disrupted attachments (those without an opportunity to form a selective attachment early in life) and therefore it is less helpful as a diagnosis to inform which children might benefit from DDP.
- The term Developmental Trauma can be helpful to describe the experience of many of the children who are fostered or adopted but it is not used as a diagnosis to inform which children might benefit from DDP.

- DDP recognizes that many children who live in adopted and foster homes have disorganized attachments leading to a range of emotional problems. We also recognize that these problems will be expressed differently with increasing maturity. DDP also recognizes that many of the children struggle to engage in intersubjective relationships, developing controlling rather than reciprocal relationships. Again this difficulty is expressed differently with increasing maturity. We observe in our clinical work the many struggles that the children have to feel safe with parents or to be open to the influence of the parents. This appears to be at the core of many of their difficulties. Therefore the practice of DDP is informed by Attachment Theory (most recently Bowlby, 1988/98) and Intersubjectivity Theory (Trevarthen, 2001).

Dr Mercer focuses on DDP as a therapy for children and young people in her article and appears to be unaware that this model also focuses attention on the parents' resilience and on parenting support.

- The DDP model informs parenting support. We recommend that the practitioner works first with the parent prior to, or at times instead of, beginning joint sessions with the parent and child. A DDP informed model of parenting has been developed with efficacy demonstrated through a number of small research studies (Golding, 2014).
- As part of this work the DDP Practitioner will work with the parents on the impact the child has upon them, including any connection with past relationship and attachment history. This increases the trust between parents and therapist, increases understanding of the intervention model and facilitates greater safety for the child or young person upon entering joint sessions.
- We use the term Dyadic Developmental Practice to recognize that DDP has a broader focus beyond therapeutic work with the child or young person (See Casswell et al, 2014). The practice model has particular appeal in the UK. Here social care and health services are often set up to provide specialist support to foster and adoptive parents, with scant resources and limited options for direct therapy.

Theoretical underpinnings of DDP

In her paper Dr Mercer connects DDP to four conceptual maps of psychological realities that she refers to as metaphors. These four metaphors are infant development, attachment, psychoanalytic, and the "Attachment Cycle". She provides considerable analysis of these metaphors questioning the assumptions which she perceives as present within DDP, informed by these metaphors.

- Infant Development and Attachment: DDP theory does not assume that child psychotherapy is parallel to normal infant development and can be modelled on it. Neither do we expect that imitation of parent – infant interactions will have the same effect on older children as the original events have on infants. We do recognise the large body of research which shows how relational

patterns developed in the early years lead to patterns of relating that can extend into adulthood and beyond. These patterns are modifiable through new attachment relationships. The focus in DDP is on the development of a secure attachment at the age and developmental maturity the child has reached in the present whilst recognising the past experience, including infant experience, which has led to the development of current fears and insecurities.

- The psychoanalytic notions of regression and catharsis/abreaction and the notion of "attachment cycle" are not found in the training of Certified DDP Practitioners within DDPI. Therefore discussion of these concepts is not relevant to the practice of DDP.
- Dr Mercer refers to Peter Fonagy's discussion about the notion of a misconceived metaphor in some treatments (although not DDP). Actually the attachment metaphor utilized by DDP has many similarities with the attachment foundations of Fonagy's work (Fonagy et al, 2002). Fonagy believes that a central feature of attachment is to facilitate reflective functioning and mentalization. These are the central mental functions that serve as the goal for his model of treatment. These functions are deficit in many abused children and their development is a central goal of the affective-reflective dialogue and the therapist's attitude of nonjudgmental curiosity that creates the momentum for such dialogues.

Dr Mercer asks some specific questions of DDP:

- Is DDP derived from Holding Therapy/Attachment Therapy? No, DDP does not advocate regression or catharsis, nor "embracing the child and managing eye contact, tone of voice, touch, and movement." DDP practitioners would not force communications involving eye contact, tone of voice, touch or movement on a child.
- Use of touch within DDP. The caregiver is present and will offer comfort, nurture, and playful touch to their child as appropriate during therapy sessions. This always occurs in a totally voluntary manner for the child. Because the foster or adoptive parent is present during the therapy the child is likely to experience much greater safety with regard to touch than if the child were in individual therapy. Touch is a natural occurrence and is never used as a technique to build a relationship. "Cradling" was referenced as one therapeutic technique in 1997 by Dan Hughes, but by 2000 it was discarded as being confusing and unnecessary for the child. Since 2000 Hughes has taught that expressions of comfort and affection between parent and child be natural and spontaneous expressions of their relationship and should not be used as interventions designed to build the relationship.
- Is DDP a Method that uses "Corrective Emotional Experiences"? This phrase is not part of the training of the DDP practitioner certified by DDPI. Mercer suggests that what is needed is new thinking about past events, not the

emotional expression of past events. The practice of DDP fits with this. The DDP therapist does not evoke emotions but rather assists the child to regulate whatever emotions emerge as the child safely explores events from the present, and when appropriate how these link to past experience. John Bowlby, the founder of Attachment Theory, suggests that the first goal of therapeutic work is to provide security. A therapist who is 'reliable, attentive and sympathetically responsive…. to see and feel the world through his patient's eyes, namely to be empathic.' (Bowlby, 1988, p140). Bowlby further writes that the aim of therapy is to enable the 'patient' to construct or re-construct working models of self and attachment figures. In this way Bowlby suggests '…he becomes less under the spell of forgotten miseries and better able to recognize companions in the present for what they are.' (Bowlby, 1988, p137). Bowlby was writing about therapy for adults but this advice is very applicable to children and young people and is compatible with the DDP model.

Evidence base for DDP

We do not dispute the lack of an RCT informed evidence base for DDP. We also acknowledge that the research carried out by Becker-Weidman was not a full RCT trial and does contain methodological problems. We are therefore actively seeking collaborations and funding to pursue a more methodologically sound trial of DDP, and have done some preliminary mapping work towards this end. It is also important to note that we do not have an evidence base for any intervention aimed at helping adoptive and foster families caring for children who have experienced complex trauma. DDP needs a stronger core of empirical evidence going forward for it to become an established intervention for children who have experienced intrafamilial abuse and neglect.

In addition DDPI is currently sponsoring practice-based data collection as a starting point for developing an evidence base. Therapists certified in DDP are administering pre and post treatment measures to evaluate the effectiveness of DDP in their practice

Whilst it will take several years to establish the high quality research evidence base which will give fullest confidence to commissioners interested in DDP, it is important that those involved in the development of this intervention ensure that it conforms to the evidence we do have for successful intervention models. This provides a safeguard for those choosing this intervention, and allows practitioners to practice safely whilst contributing to the data collection which will build the research evidence base.

It should be noted that DDP is, at its core, a relationship focused therapy and the therapeutic relationship is central in its effectiveness. There is extensive research that indicates that the therapeutic relationship is crucial for the effectiveness of psychological treatment, regardless of the treatment method employed. Therapeutic relationships are characterized by a strong therapeutic alliance, empathy, and

unconditional positive regard (Norcross & Wampold, 2011). All three of these evidence-based relationship components are central in the training and practice of therapists certified in DDP through DDPI.

A Call for Research

DDP has been developed by Dan Hughes based on many years of clinical experience of children and families together with a close study of relevant theory. This has produced a robust model informing both parenting support and therapeutic interventions. DDP is very ready to be put to the research test.

At a recent training event an adoptive parent approached one of us and told how much difference it had made working with a DDP therapist. A foster parent said her relationship with her foster daughter was transformed when she applied DDP informed parenting advice. These are anecdotes, and therefore do not provide us with evidence. However we hear many stories like these. We owe it to these parents and many like them to continue to develop research programs exploring the efficacy of DDP. This will provide confidence that this model makes a difference for the children and their families and allow us to further develop the interventions tailored to the needs of the families.

We therefore welcome expressions of interest and funding to collaborate with us in providing DDP with a research base which will match the strong clinical and theoretical base that we already have.

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