DDP Therapy Referral Guidance

Dyadic Developmental Psychotherapy Institute (DDPI) and DDP Connects UK

This guidance aims to help commissioners and referrers (from social, health, educational, and court services) in deciding whether Dyadic Developmental Psychotherapy (DDP) is a helpful and appropriate intervention to explore. To save repetition, 'parents' is used interchangeably for one or more parent(s) and caregiver(s). 'Child/ren' is used interchangeably with 'young person'.

It is not intended to replace professional assessment by a competent, trained and knowledgeable medical, psychological, mental health, social care or child developmental professional. Neither the Dyadic Developmental Psychotherapy Institute (DDPI) nor DDP Connects UK are liable for any consequences arising from use of this guidance.

Who Does DDP Help?

- This guidance provides information when considering referrals for DDP as an intervention to support children and young people who have experienced high family stress/adversity, complex trauma (including abuse and neglect in their early years), developmental trauma and/or significant disruption in their attachment relationships, that is causing significant impairment in their day to day functioning.
- DDP is most often used with children who have been adopted, fostered, or living in residential or kinship care. It can also help children who live with their birth parents so long as the current home and parenting provided is safe and nurturing. When this is lacking, the DDP practitioner may work with the parents aiming to help provide appropriate safety and nurturance to the child.

What Does DDP Aim To Do?

- DDP is a therapeutic approach developed to meet the specific developmental needs of children and young people who have experienced significant adversity and interpersonal trauma, often in the context of their primary attachment relationships. It focuses primarily on the central importance of healthy and supportive relationships to aid trauma recovery.
- DDP aims to enable children to experience safety, security and increased trust in their relationships with their parents, and to develop deeper emotional connection (and emotional processing) in the child-parent relationship. The capacity to trust and use others for support is a significant protective/resilience factor in trauma recovery and positive mental health. This foundation enables safe processing of trauma memories, emotions and experiences. It enables new meanings about past experiences to develop and increases self-regulation (managing high arousal and distress). This is a particularly important aim for therapy, given that early, multiple or repeated experiences of interpersonal trauma and/or attachment disruption significantly reduces a child's sense of trust and relational safety. It can also maintain fear and avoidance of healthy emotional connection, even in the context of new caregiving relationships (e.g. fostering or adoption).
- Within this context of family/placement safety, DDP aims to facilitate the child's emotional, cognitive, social, and psychological development.

DDPI and DDP Connects UK thank Dr Billy Smythe, Clinical Psychologist, Phoenix Psychology & Dr Marie Kershaw, Clinical Psychologist, Birmingham Children's Trust for their work developing this guidance *29th March 2019*

How does DDP work?

- Key to the DDP model is PACE - playfulness, acceptance, curiosity and empathy - a way of thinking, feeling, communicating and behaving that aims to help the child feel safe, experience increased emotional regulation, and discover new meanings about self, others and the nature of relationships.
- Referrals for DDP often include an assumption that the child will be involved in therapy from the start. This is not necessarily the case. DDP is a systemic model that works with various combinations of child/parent/professionals as appropriate to best meet the family's needs. A DDP intervention typically includes work with the network around the child as well as 'parent only' sessions. This work helps the parents and network better understand the child's needs, presenting difficulties and respond in ways that build the relationship, increase safety and security alongside responding appropriately to concerning behaviour.
- Initially, parents work with a DDP Practitioner (without the child present) to safely explore and process their experience of parenting, including 'blocked care' that may be impacting on their current ability to parent, care for and meet the needs of the child. Past relationships and, if relevant, past traumas are explored. Parent work can be the 'stand-alone' intervention or a pre-requisite to therapy with the parent and child in the room together.
- Once parents are assessed as understanding the model, and able to appropriately support the child through therapy, the child may join the therapy sessions. Parent only sessions continue alongside parent-child sessions and may continue once parent-child sessions come to an end. Sessions may also take place with the professional network supporting the family (e.g. school, social care) to ensure consistency of approach across settings.
- Sometimes children don't have parental figures who are able to be involved in therapy. In these situations, the DDP Practitioner may see the child with other key supportive individuals in the network, keeping any parental figures closely involved as appropriate.
- Sometimes adolescents request therapy, or a separate confidential space, to begin exploring issues, but do not want their parents involved. Separate sessions for an adolescent and their parents may be considered if this is part of a 'joined up' and coherent package of support.
- DDP principles and practice can also be applied to support children in residential settings. This is discussed in additional guidance 'DDP for young people in residential homes

Key Points For Commissioners And Referrers
1. DDP is a comprehensive, systemic model of intervention. An initial assessment by a DDP trained practitioner is important to determine if DDP therapy is appropriate.
2. DDP addresses parental, contextual and child factors to best meet the assessed needs of the child. Therapy may include any combination of 'Parent-Only' sessions, 'Parent-Child Together' sessions, and/or 'Support to The Professional Network' For 'Parent-Child Together' sessions, pre-session contact (face to face or telephone) with parents/ supporting professionals is an essential part of DDP. It provides support, parental emotional regulation, psycho-education and session planning to maximise safety within sessions. As such, all component parts of the intervention must be commissioned and funded as a comprehensive whole. In cases where parents are not able to be involved, support to the child's network (to develop a shared understanding of the child's needs in the context of their current situation) is still vital before therapy involving the child may be of value.

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3. Those commissioning DDP should ensure that the therapy is being delivered by trained practitioners with ongoing clinical supervision.

4. It is important to recognise that families may need more than one 'block' of therapy over time. Therapy may need to be 're-visited' intermittently as the child reaches different developmental stages or experiences events that trigger a trauma response. This should not be seen as a failure of the therapy or the family. This is in recognition of the often complex, habitual and entrenched nature of difficulties, the developmental capacity of children to process trauma, and the nature of the care system where children's attachment figures and/or contexts may change e.g. adoption transition, foster placement moves, leaving care. Each block of therapy should be preceded by an assessment, re-formulation and include regular review to identify coherent therapy aims.

5. Where the presenting issue involves significant risk of family/placement breakdown or involves a plan of reunification home, therapy needs start with the parents and include representatives from relevant professional networks.

6. In recognition of high levels of avoidance, mistrust, and engagement difficulties typically associated with developmental/complex/relational trauma, DDP is unlikely to be a short-term intervention. Observable changes in the child's behaviour and emotional well-being may take time. A timescale of 6-9 months is often recommended, but it would be common for therapy to take longer.

Checklist When Considering a DDP Referral

Has the child experienced complex/developmental trauma and/or significant attachment disruption? Are these associated difficulties central to the referral and presenting difficulties?	Yes ↓	No	DDP is one of various therapies and support options for children and families depending on primary presenting issues. If this is not the primary issue, you may wish to consider other approaches as appropriate to best meet need.
Are there questions about a child's age and/ or their capacity to engage in DDP? Is there shared agreement that the child can engage in DDP? Do the aims of DDP therapy fit the presenting need?	Yes ↓	No	Assess discrepancies in perspective, review primary presenting issues and DDP aims.
Is the child in a stable/secure family or placement that will continue? (i.e. not on the verge of a placement disruption, a move, or transition). Is there a commitment to develop emotional connection and placement/ relational stability?	Yes ↓	No	Carefully consider, with a DDP Practitioner, the timing and goals of involving the child. Parent only sessions and/or network support is likely to be effective in the first instance to help assess and /or increase placement and relational stability before considering therapy involving the child.

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Are parents willing to try and make sense of the trauma the child has experienced?	Yes ↓	No	Initial assessment and parenting support may help establish the blocks and barriers to this (referred to as 'blocked care'), establish if this can be changed and what may be needed to help and support the parents.
Initially Parent-Only sessions are required to help parents understand the model and the central role they have within it. Where there are two parents, both will be included in the work wherever possible. Are parents prepared to explore their experiences of parenting their child, their parenting approach, their own triggers, past relationships and traumas with a DDP Practitioner? Is there a parent who is prepared to be part of DDP therapy (including parent- child sessions) and is committed to a relationship focused way of working?	Yes ↓	No	Some parents initially struggle to understand the relevance of this work to their child's recovery, or struggle to commit due to 'blocked care' or other factors. Parent consultations can be undertaken to develop parental engagement. Parents can be supported to build a trusting relationship with a practitioner, to see the value of this work, and to engage in the parenting support, though this may take time. There are some circumstances where, despite support, parental engagement cannot be achieved, but where a child may still benefit from therapy with a relational approach to support trauma recovery or the development of relational safety. For example, supporting adolescents, family breakdown, parental mental health issues, young people in residential care. There may be a key adult in the child's support network who could undertake the 'supportive adult' role in lieu of a parent. Alternatively, the DDP Practitioner may undertake individual sessions with the young person whilst work in conjunction with the professional network. However, agreement from the person who holds parental responsibility, and continued parent support (even if from a distance) is still encouraged, with the aim of facilitating the parent-child relationship. If no appropriate alternative adult is identified, DDP consultation to the professional network may still be beneficial in developing an understanding of the young person's needs/presentation and to help inform future care planning.
Where parents have been involved in past harmful behaviours towards the child, or where they were not able to adequately protect the child from harm, are they willing to reflect and accept responsibility for past behaviours?	Yes ↓	No	DDP needs to begin with parent-only sessions to work through these issues before bringing the child into therapy. DDP involving child-parent sessions are not effective or 'safe' without this, as parents could inadvertently reinforce blame, perpetuate shame or minimise the impact of trauma with detrimental effect.
Have neurodevelopmental difficulties been considered as causal factors in addition to complex/developmental trauma and/or attachment disruption?	Yes ↓	No	Consider a neurodevelopmental and/or sensory assessment to more fully understand needs and ensure these are appropriately attended to within therapy and as a complement to DDP therapy.

To further aid decision making, you may wish to utilise the 'Assessment Grid' (Golding, K. 2018)
https://ddpnetwork.org/library/ddp-pyramid-of-need-and-assessment-grid/
For research base and outcome studies please refer to https://ddpnetwork.org/about-ddp/research-evidence-base-outcomes/

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