Dyadic Developmental Psychotherapy (DDP): Using Relationships to heal children traumatised within their early relationships

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Q. What is DDP?

A. Dyadic Developmental Psychotherapy is part of a model of intervention which also includes Dyadic Developmental Parenting and Practice. This is collectively known as DDP. Together this represents a wraparound model of intervention for working with children, families, residential settings and schools. For example the therapist might help the parents[1] to parent the children in ways that emotionally connects with them and helps to increase their feelings of security; meet with the teachers and support staff to help them to support the child in school to feel safe enough to learn; and provide therapy for the child supported by his or her parents. This intervention is most typically used to support children who have experienced developmental trauma (sometimes called complex, relational trauma) in their early years. Many of these children are living in foster care, adoptive families, kinship care or residential care.

Q. What is Developmental Trauma

Developmental trauma is a descriptive term to describe the impact of children's experience of frightening or unavailable caregiving early in life. This might include abuse, neglect, exposure to frightening environments, and the lack of a stable home. For some children the damage starts within the womb because of the impact of drugs, alcohol and maternal stress. Many of these children also experience the loss of birth parents and very stressful transitions through the care system and into adoptive homes. This early experience impacts on the developing nervous system influencing many aspects of the child's development. This can include difficulties with attachment to new parents; biological processes such as difficulties with sleeping, eating, and health; regulation problems that mean the child either dysregulates - finding it hard to calm when arousal becomes too high (such as getting excited or

[1] Within this article we use the term 'parent' to refer to anyone parenting children whether or not these are their birth children.

distressed) or dissociates – a process of shutting down to manage the high arousal; behaviour control when the children find it hard to manage their strong feelings and impulses leading to behaviours that are challenging for themselves and others; cognition involving problems in thinking things through, understanding what might happen as a consequence of what they are doing or generally making sense of their experience; and with their self-concept - many of the children grow up with a sense of being bad and unlovable while also often having an unstable sense of self that makes transitions difficult. Children with this experience can grow up with lifelong difficulties; including chronic feelings of shame, an inability to manage stress and difficulties trusting others for guidance, comfort and support.

Q. Why was DDP developed?

A. DDP was developed by Dan Hughes whilst he was working as a clinical psychologist in USA. Dan was feeling frustrated that tried and tested therapies were not helpful for children and families when the children had been exposed to developmental trauma. Therapy relies on the relationship between the therapist and the child. When children have been frightened within or separated from their first attachment relationships these children became so fearful of later relationships that they can often struggle to form a safe relationship with a therapist. Dan realised that therapy could not focus on the trauma until the children had discovered ways to feel safe in their current relationships, especially with their parents or caregivers.

Within DDP, the children are offered new relational experiences modelled on healthy parent-child relationships. These relationships are unconditional, most clearly demonstrated through the attitude of PACE. The therapist uses this attitude to guide a way of being with the children resting on playfulness, acceptance, curiosity and empathy. This provides emotional connection and sufficient safety that the children can begin to develop new ways of being within this relationship. The therapist also helps the parents to hold this same attitude and therefore also offer a different relationship experience.

Within safe relationships children can develop trust. They learn to seek support to help them to identify, regulate and safely express emotion. As they become better regulated, reflective capacities can increase. They can think about and make sense of their experience whether this is in the present or from the past. Now the children are ready to develop new narratives about their experience and they can start to heal from the traumatic experience they endured.

Q. Why does the therapist need to work with the parents before providing therapy for the child?

A. Parents are the most important people in a child's life. They therefore have a central role in their child's therapy. Learning to feel safe with parents can be very hard when early experiences have been frightening. By being involved in the child's therapy the child can get a different experience of his or her parents. With this different experience children can recover trust and begin to feel secure within their families. It is therefore important that parents and therapist get to know and trust each other. Parents will be able to help the therapist to get to know the child and will learn from the therapist different ways of being with and parenting the child. This includes learning how to parent with PACE so the child will experience this attitude at home as well as in the therapy room. The therapist will want to explore with the parents how the child's difficulties are impacting upon them. This will help the parents to reduce feelings of defensiveness and to be more open and emotionally engaged with their child. Part of this exploration will involve thinking about the parents own life experiences, especially the parenting they received and how this has impacted on their parenting of their child. Sometimes parenting children who are traumatised can trigger strong feelings based on memories of difficult previous relationships. Understanding these triggers can help parents to be more available to their child when he or she needs it. The therapist will also want to help if the parent is finding parenting hard, affecting their emotional wellbeing. Sometimes parents find parenting their children very unsatisfying even though they continue to have a big commitment to them. Dan and Jon Baylin have explored how this can impact on parental nervous systems leading to blocked care. This suggests that there are neurological reasons why parenting a child who does not respond to good care makes it difficult to be able to continue to provide such care consistently. Often when the parent is supported by a caring therapist who holds the attitude of PACE for them, that parent will find that parenting feels easier even though the child has not changed.

Working with the therapist before and during the therapy will help parents to feel supported, to understand more deeply what is going on for their child as well as what is happening within the therapy, to understand what is being expected of them in the therapy room, to explore different ways of parenting their child to help him or her to feel more secure and to find ways to feel closer to their child if this is currently missing for them both. These experiences are likely to be crucial in keeping alive the hope that their parenting will make a significant difference in their child's life.

Q. What is PACE?

A. PACE consists of the four elements of playfulness, acceptance, curiosity and empathy. These were brought together as an attitude by Dan as a way of helping the adult remain emotionally engaged and available to the child. It is modelled on the way that parents relate to their very young children. PACE helps the therapist and the parents to demonstrate to the children that they are available and sensitive to their needs. They do this by offering an unconditional relationship within which the adult maintains a curiosity about the inner life of the child and accepts this without judgement or evaluation. This acceptance is communicated with empathy for the struggles this experience can bring. PACE also offers the child fun and joy within the relationship; moments of healthy relationship and respite from the day-to-day struggles. PACE is a way of being rather than a technique. The adult wants to be with and to understand the child without an immediate motive to change him. PACE allows the adult to get alongside the child and to support and share the experience the child is having. Over time the child develops a new understanding about himself and expectations of others because of this experience. Notice that PACE is not about trying to change behaviour. Therapy is concerned with understanding the child and helping him or her to transform his understanding of past and current experience. Lasting behaviour change begins with changes within the mind and heart of the child; changes built upon emerging trust and understanding of both self and other. In DDP-informed parenting the parent combines PACE with behavioural support so that discipline does not inadvertently undermine the more secure relationship that is developing.

Q. What should parents and children expect when attending DDP sessions together?

A. The therapist will have a catch-up with the parents when the child is not present to find out how the week has gone and to check in with how the parents are feeling. It is helpful to do this with a telephone call either on the same day or a day or two before the session including the child. Another way is to catch up at the start of the therapy session, making sure the child is with someone they feel safe with. The session with the child will then start.

The therapist will start by chatting to the child, helping him or her to feel safe and settled. The therapist chats with a storytelling tone of voice which demonstrates his interest in getting to know the child. It doesn't matter if the child does not join in with the talking. Some

children will listen whilst the therapist talks to them or to the parents about them. The therapist will use the child's non-verbal communication (nods, shrugs, smiles etc) to judge whether he is getting things right or needs to adjust his understanding. Gradually the conversation will touch on themes that are more troubling for the child whilst still using this storytelling rhythm and tone. This will include making sense of what has happened during the week. When it seems relevant the therapist will also talk about the child's past experience. This will be done to help the child make better sense of how he or she is feeling currently. For example, imagine a boy got very angry with his mother for taking his sister out and not him. Through chatting with him the therapist helps the child to understand that his anger was because it felt like his mother loved his sister more than him. He then thinks about what it was like for the child in his birth family when his sister got the special treatment whilst he had to stay in his bedroom. The therapist will notice that it is no wonder that he felt angry with his mum in the present because of this past experience. He helps the child to communicate this to his parents within the session and they will respond with understanding and empathy for how hard this has been. The child begins to understand how his past trauma is still affecting him in the present, he becomes more motivated to understand it differently, as well as experiencing less shame over his current behaviours. The child gets an immediate experience of being loved and cared for by his parents which is in contrast to how he felt when he was little. He can start to believe that maybe he is loveable and that his parents do love him as well as his sister.

Q. How does my family get referred and funded for DDP?

A. The availability of DDP practitioners is increasing but is still patchy around the UK.

Local child and mental health services within the NHS are more likely to offer shorter term interventions, although in some areas they have specialist practitioners or teams supporting families of children adopted or living in care. These specialists may have DDP practitioners within them, so it is worth talking with your GP.

Your local adoption support team will also know the DDP therapists in the area. They will support you to make a referral. If you are living in England, they can also make an application to the Adoption Support Fund for funding to support the therapy.

Regional Adoption Agencies (RAA's) are also a new English development which may have an impact in the future on how adoption support services are accessed and provided locally.

Adoption Central England has made a commitment to embedding DDP into the agency and are working towards becoming a DDP certified organisation.

In Wales, Adoption UK, collaborating with BAAF, was instrumental in bringing DDP training to Wales 6 years ago. Under the National Adoption Service, Welsh local authorities now work together within five regional collaboratives to provide a range of adoption services. Some directly provide adoption support services whereas in others this remains with their local authorities.

In Scotland, Edwina Grant has been working closely with Dan Hughes to provide DDP training for many years although there remains limited availability of DDP practitioners.

Northern Ireland has similarly supported DDP training and a few practitioners have moved on to become certified.

There are currently no certified practitioners within the Republic of Ireland, but a few practitioners are actively supporting bringing training into the country and are working towards certification.

Finally, our website (ddpnetwork.org) has a '[Find a Practitioner]' section where you can see who is working within your locality.

Q. Does DDP work?

A. Research has been carried out to show that DDP is effective. This includes a qualitative study of the therapy within which parents reported that the therapy had made a difference to their child and for them as a family. Studies of parenting programmes based on the DDP principles have shown that parents feel more effective, have better understanding and feel more competent parenting their children once they have participated in the programme. Research has also been carried out in schools to show that the children benefit when their teachers and support workers use the DDP principles. You can find out more about this research on the DDP website alongside lots of other information about DDP (ddpnetwork.org). The next step in helping us to know how effective DDP is requires a Randomised Control Trial (RCT) of the therapy. This will involve families who are experiencing DDP to report on their progress through interviews and questionnaires. This will be compared with similar families undergoing different interventions. The analysis of

this data will help us to better know what works for children who have experienced developmental trauma and will help families to find the best intervention for their child.

Q. When will the RCT trial happen?

A. The National Institute for Health Research (NIHR) has agreed to fund a programme of research to examine the clinical and cost-effectiveness of Dyadic Developmental Psychotherapy (DDP) compared to services-as-usual. The total amount of the award is £2.1 million. The study, due to start in March 2020, will be led by Helen Minnis, Professor of Child and Adolescent Psychiatry at the University of Glasgow. Care experienced young people, parents (including foster carers and adoptive parents), health and social care commissioners will be central to the research so that, whatever the outcome, we will learn about how best to deliver services to children who have experienced abuse and neglect and the families in which they have been placed.

The grant has been awarded based on a strong argument that evidence based interventions for children who have a background of maltreatment are lacking. DDP has been identified as an intervention which may address many of the consequences of early adversity on children. The proposed project will have three phases; phase one will ensure the services and context which provide DDP and the comparison intervention-services as usual-can adequately provide for the range of difficulties which children in foster and adoption may have experienced. This will ensure a fair comparison between DDP and the control condition. Phase two will test how a randomised trial might work and if the conditions are satisfied which make a definitive trial possible including recruitment of enough families, and good compliance with the demands of a trial. Following this the full trial can go ahead. If all goes well it is projected this will be completed in four years.

Q. How can I find out more about DDP?

A. The website (ddpnetwork.org) has lots of information about DDP. This includes details about a range of books written about DDP.

Useful starting points for reading about DDP are Dan's books. You could begin with '*Building the Bonds of Attachment, Awakening love in deeply troubled children'*. This was

published in 2017 in a 3rd edition by Jason Aronson. You might also find his '*Attachment-focused Parenting'* published in 2009 by W. W. Norton helpful.

Kim's most recent book published in 2017 by Jessica Kingsley Publishers adds to this. It is called '*Everyday parenting with security and love. Using PACE to provide Foundations for Attachment'*. Kim and Dan have also written a book about PACE together. This is called '*Creating Loving Attachments. Parenting with PACE to nurture confidence and security in the troubled child'*. This was published by Jessica Kingsley Publishers in 2012.

Dan has written two books with his colleague Jon Baylin to help parents understand blocked care and blocked trust. '*Brain-Based Parenting: The Neuroscience of Caregiving for Healthy Attachment*' was published in 2012 and '*The Neurobiology of Attachment-Focused Therapy: Enhancing Connection & Trust in the Treatment of Children & Adolescents'* in 2016 both by W. W. Norton.

If you want something even more detailed and up to date about the DDP model, our most recent publication is called *'Healing Relational Trauma with Attachment-focused interventions: Dyadic Developmental Psychotherapy with Children and Families'*. This was written by Dan, Kim and Julie Hudson and was published in 2019 by W. W. Norton.

For group support, Kim has developed two groupwork programmes to support parents parenting children with experience of developmental trauma. These are the *'Nurturing Attachments Training Resource'* and *'Foundations for attachment training resource'*. Your local adoption team will know if these are accessible in your area.

Kim Golding is a Clinical Psychologist, Author and DDP trainer living and working in Worcestershire, UK. Kim has always been interested in parenting and collaborating with parents to develop their parenting skills tailored to the needs of the children they are caring for. She worked within the NHS for over thirty years and now works independently, primarily providing consultation, training internationally, and support to parents and practitioners who are helping children with experience of developmental trauma.

Dan Hughes is a Clinical Psychologist, Author and DDP trainer living and working in South Portland, Maine, USA. He provides supervision, consultation, and training in DDP internationally.

