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# Dyadic Developmental Psychotherapy: An Evidence-Based and Effective Treatment for Trauma and Disorders of Attachment

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## INTRODUCTION

The purpose of this article is to outline several of the elements of Dyadic Developmental Psychotherapy and demonstrate the evidence base for those components. While there have been a two outcome studies using control groups that demonstrated the overall effectiveness of Dyadic Developmental Psychotherapy, the treatment is an integration of several approaches, methods, and techniques that each have strong evidence and empirical bases. The two outcome studies, coupled with the evidence base for the components of Dyadic Developmental Psychotherapy, provide support for the efficacy of this model of treatment. A recent meta-analysis (Craven & Lee, 2006), based on the partial and preliminary results of one study in 2004, determined that Dyadic Developmental Psychotherapy is, "supported and acceptable" (p.301).

There has been a substantial amount of confusion and controversary about the diagnosis and treatment of Reactive Attachment Disorder (O'Connor & Zeanah, 2003). Attachment therapy, holding therapy, and other terms are often used interchangeably, as are RAD or Reactive Attachment Disorder, Attachment Disorder, and related terms, which only adds to the confusion. Dyadic Developmental Psychotherapy is not a "holding therapy" as defined by O'Connor and Zeanah (2003). They describe "holding therapy" as being based on "rage reduction" techniques and that, "the holding approach would be viewed as intrusive and therefore *non-sensitive* and counter therapeutic" (Italics added, p. 236). Dyadic Developmental Psychotherapy has as its core, or central therapeutic mechanism for treatment success, the maintenance of a contingent, collaborative, sensitive, reflective, and affectively attuned relationship between therapist and child, between caregiver and child, and between therapist and caregiver. Dyadic Developmental Psychotherapy focuses on and relies upon the intersubjective sharing and joint development and organization of emotional experience.

Children who have experienced chronic maltreatment and resulting complex trauma are at significant risk for a variety of other behavioral, neuropsychological, cognitive, emotional, interpersonal, and psychobiological disorders (Cook, A., et. al., 2005; van der Kolk, B., 2005). Many children with histories of maltreatment are violent (Robins, 1978) and aggressive (Prino & Pyrot, 1994) and as adults are at risk of developing a variety of psychological problems (Schreiber & Lyddon, 1998) and personality disorders, including antisocial personality disorder (Finzi, Cohen, Sapir, & Weizman, 2000), narcissistic personality disorder, borderline personality disorder, and psychopathic personality disorder (Dozier, Stovall, & Albus, 1999). Neglected children are at risk of social withdrawal, social rejection, and pervasive feelings of incompetence (Finzi et al.,

2000). Children who have histories of abuse and neglect are at significant risk of developing Post Traumatic Stress Disorder as adults (Allan, 2001; Andrews, Varewin, Rose, & Kirk, 2000). Children who have been sexually abused are at significant risk of developing anxiety disorders (2.0 times the average), major depressive disorders (3.4 times average), alcohol abuse (2.5 times average), drug abuse (3.8 times average), and antisocial behavior (4.3 times average) (MacMillian, 2001). The effective treatment of such children is a public health concern (Walker, Goodwin, & Warren, 1992).

Children and adolescents with complex trauma require an approach to treatment that focuses on several dimensions of impairment (Cook, et. al., 2005). Chronic maltreatment and the resulting complex trauma cause impairment in a variety of vital domains including the following:

- Self-regulation
- Interpersonal relating including the capacity to trust and secure comfort
- Attachment
- Biology, resulting in somatization
- Affect regulation
- Increased use of defensive mechanisms, such as dissociation
- Behavioral control
- Cognitive functions, including the regulation of attention, interests, and other executive functions.
- Self-concept.

Dyadic Developmental Psychotherapy addresses these domains of impairment. Dyadic Developmental Psychotherapy shares many important elements with optimal, sound social casework and clinical practice. For example, attention to the dignity of the client, respect for the client's experiences, and starting where the client is, are all time- honored principles of clinical practice and all are also central elements of Dyadic Developmental Psychotherapy. What distinguishes Dyadic Developmental Psychotherapy from other methods of clinical work with children, such as Cognitive Behavioral Therapy, is the strong emphasis on maintaining an intersubjective relationship with the child, deep acceptance of the child's affect and experience, non- judgmental curiosity about the meaning the child has given to the events of the child's life, and greater emphasis on experience and process rather than on verbalization and content. Dyadic Developmental Psychotherapy requires a greater use of self in both the here-and-now experience of the child as well as in the expression of that experience to the child, than, for example, does Cognitive-Behavioral Psychotherapy, behavioral approaches, or strategic or structural family therapy interventions.

## DYADIC DEVEOPMENTAL PSYCHOTHERAPY

Dyadic Developmental Psychotherapy is a treatment developed by Daniel Hughes (Hughes, 2004, 2005, 2006). A more complete description of the treatment approach including specific

techniques and methods along with case examples can be found in Becker-Weidman & Shell (2005). Its basic principles are described by Hughes (2004, 2005, 2006) and Becker-Weidman & Shell (2005) and summarized as follows.

1. A focus on both the caregivers' and therapists' own attachment strategies.

   Previous research (Dozier, 2001, Tyrell 1999) has shown the importance of the caregivers and therapists state of mind for the success of interventions.

2. The therapist and caregiver provide the intersubjective experiences for the child that are seldom present in situations of abuse and neglect. These intersubjective experiences are characterized by shared affect (attunement), joint focus of awareness and attention, and complementary intentions. Intersubjective experiences are the primary means whereby the infant and young child learn about self, other, and the world (Trevarthen, 2001). Intrafamilial trauma will significantly disrupt the development of intersubjectivity and increase the risk that the child will be unable to create a coherent meaning for many events and especially traumatic ones. Facilitating intersubjective experiences between the therapist and caregiver and the child enables the therapist and caregiver to co- regulate emerging affect that is associated with traumatic or other stressful events, while at the same time, co-create new meanings of these events. When the therapist and caregiver manifest a clear intention to provide such intersubjective experiences, when their attention is focused and non-judgmental, and when their affect is regulated, the child often, for the first time, has the opportunity to organize a coherent experience around the traumatic event.
3. In some situations the caregiver's own attachment style may create barriers to the caregiver's ability to create a positive shared intersubjective experience with the child. In these instances, it is important for the therapist to provide intersubjective experiences for the caregiver that are positive, supportive, and, therefore, healing. When these issues are true as well for the therapist, the therapist needs to address the difficulty in supervision or therapy for himself or herself.
4. Use of PACE and PLACE. These acronyms describe the "attitude" of the therapist and caregiver. PACE refers to the therapist setting a healing pace to therapy by being playful, accepting, curious, and empathic. Through PACE the therapist is able to both generate and regulate though empathy (and playfulness when appropriate) the emerging affect that is associated with events being explored. The therapist is also able to facilitate an open, reflective attitude to reorganizing the experience of these events through her accepting and curious stance. PLACE refers to the parent creating a healing environment by being playful, loving accepting, curious, and empathic. These ideas are described more fully in Becker-Weidman & Shell (2005).
5. The inevitable misattunements and conflicts that arise in interpersonal relationships are directly addressed and then repaired through the ongoing qualities of the relationship (PACE). The need for repair is especially important since the themes often being explored are often characterized by shame and fear. Repair helps with both affect regulation and directly challenges the distorted beliefs of being alone in handling affects.
6. Caregivers use attachment-facilitating interventions that meet the developmental needs and state of the child. These include interventions that facilitate safety, emotional communication, reflection, conflict resolution skills, and the ability to both seek and receive comfort and guidance. The effective application of these supportive and emotionally-responsive and sensitive interventions does require that the caregiver have a reasonably well developed reflective function and ability to engage in the intersubjective sharing of affect and meaning in a relatively undistorted manner.

The primary approach is to create a secure base in treatment (using techniques that fit with maintaining a healing PACE (Playful, Accepting, Curious, and Empathic) and at home using principles that provide safe structure and a healing PLACE (Playful, Loving, Acceptance, Curious, and Empathic). Developing and sustaining an attuned relationship within which contingent collaborative communication occurs helps the child heal. Healing is facilitated by the co-regulation of affect, the co-creation of meaning, and the emerging development of greater reflective capacities (Fonagy, Gergely, Jurist, & Target, 2002) Coercive interventions (that have been attributed to other therapeutic approaches for children with trauma/attachment problems) such as rib-stimulation, holding-restraining a child in anger or to provoke an emotional response, shaming a child, using fear to elicit compliance, and interventions based on power/control and submission are never used and are inconsistent with a treatment rooted in attachment theory and current knowledge about the neurobiology of interpersonal behavior. These interventions elicit fear, which is the antithesis of security.

Treatment of the child has a significant non-verbal dimension since much of the trauma took place at a pre-verbal stage and is often dissociated from explicit memory. While other traumas occurred after the child became verbal, they nevertheless were experienced primarily nonverbally (harsh and abusive looks, voice, and touch, as well as the failure to respond to or initiate support when the child was in distress). As a result, childhood maltreatment and resultant trauma create barriers to successful engagement and treatment of these children. Treatment interventions are designed to create experiences of safety and affective attunement so that the child is affectively engaged and can explore and resolve past trauma. This process provides for exposure to the trauma and is also a way of working through the conditioned emotional responses associated with the trauma. Safety and intersubjectivity (with attunement, joint awareness and intention) address not only the maltreatment, but also directly address the underlying loss of security that chronic early maltreatment cause. Therapist and caregiver attunement results in co-regulation of the child's affect so that is it manageable. Interventions that facilitate cognitive restructuring of the distorted beliefs and the co-creation of new meanings are designed to help the child develop secondary mental representations of traumatic events and expand the child's reflective functioning, which allow the child to integrate these events and develop a coherent autobiographical narrative.

In summary, Dyadic Developmental Psychotherapy uses a variety of interventions and methods with a well-established foundation (Becker-Weidman & Shell, 2005). These interventions and domains include the following:

- Safety in emotional and physical domains
- Empathy
- Unconditional positive regard—acceptance
- Reflective function
- Relationship based (an intersubjective stance requiring the active use-of-self)
- Exploration and discovery (curiosity)
- Self-regulation of affect, cognition, and behavior, initially through the intersubjective co-regulation of these domains

- Integration of traumatic experiences and the creation of a coherent autobiographical narrative (the intersubjective co-creation of meaning)

- Positive affect enhancement (playfulness)

## EVIDENCE BASE

Craven & Lee (2006) determined that Dyadic Developmental Psychotherapy is a supported and acceptable treatment. However, their review only included results from a partial preliminary presentation of an ongoing follow-up study (2004), which was subsequently completed and published in 2006. This initial study compared the results Dyadic Developmental Psychotherapy with other forms of treatment, "usual care," one year after treatment ended. A second study extended these results out to four years after treatment ended. Based on the Craven & Lee classifications (Saunders et al. 2004), inclusion of those studies would have resulted in Dyadic Developmental Psychotherapy being classified as Category 2, "Supported and probably efficacious."

There have been two related empirical studies comparing the treatment outcome of Dyadic Developmental Psychotherapy with a control group (Becker-Weidman, 2006a, Becker-Weidman, 2006b, Becker-Weidman, 2006c). The first study (Becker- Weidman, 2006a) compared a treatment group (N=34), which received Dyadic Developmental Psychotherapy, with a control group (N=30), who received other forms of treatment at locations different from the test site by other providers. The two groups were not different on a variety of demographic and clinical measures. All children in the study met the DSM-IV criteria for Reactive Attachment Disorder. The two groups of children all had clinically significantly elevated scores on the Child Behavior Checklist. This study found that one year after treatment ended children who received Dyadic Developmental Psychotherapy had clinically and statistically significantly lower scores on the Child Behavior Checklist and that these scores were all in the normal range. Children in the control group showed no statistically or clinically significant changes in the outcome measures.

The second study, (Becker-Weidman, 2006b, Becker-Weidman, 2006c) followed this same group of 64 children and measured the outcome of treatment using the Child Behavior Checklist about four years after treatment ended. This study examined the effects of Dyadic Developmental Psychotherapy four years after treatment ended on children with trauma-attachment disorders who met the DSM IV criteria for Reactive Attachment Disorder. The treatment group was composed of thirty-four subjects and the control group had thirty subjects. All children were between the ages of five and sixteen when the study began. It was hypothesized that Dyadic Developmental Psychotherapy would reduce the symptoms of attachment disorder, aggressive and delinquent behaviors, social problems and withdrawal, anxiety and depressive problems, thought problems, and attention problems among children who received Dyadic Developmental Psychotherapy, as measured by the Child Behavior Checklist. Significant reductions were achieved in all measures studied. The results were achieved in an average of twenty-three sessions over eleven months.

These findings continued for an average of 3.9 years after treatment ended for children between the ages of six and fifteen years. There were no improvements in the control group, who were re-tested an average of 3.3 years after the evaluation was completed.

Their scores remained in the clinical range and actually became statistically significantly worse on several of the Child Behavior Checklist scales: Anxious/Depressed, Attention problems, Rule Breaking Behavior, and Aggressive Behavior.

The results are particularly salient since 82% of the treatment-group subjects and 83% of the control group had previously received some other form of treatment with an average of 3.2 prior treatment episodes. In this study a "treatment episode" was defined as a series of multiple treatment sessions beginning with an assessment, continuing with several treatment sessions over several months, and ending with termination. This past history of unsuccessful treatment further underscores the importance of these results in demonstrating the effectiveness and efficacy of Dyadic Developmental Psychotherapy as a treatment for children with trauma-attachment problems. In addition, 100% of the control group subjects received "usual care" (family therapy, individual therapy, play therapy, or residential treatment, for example) from other providers, but without any measurable change in the outcome variables measured. Children with trauma-attachment problems are at significant risk of developing severe disorders in adulthood such as Post Traumatic Stress Disorder, Borderline Personality Disorder, Narcissistic Personality Disorder, and other personality disorders.

These two studies support several of O'Connor and Zeanah's (2003) conclusions and recommendations concerning treatment. They contended, "treatments for children with attachment disorders should be promoted only when they are evidence-based" (p. 241). The results of these studies are a beginning toward that end. While there are a number of limitations to these studies, given the severity of the disorders in question, the paucity of effective treatments, and the desperation of caregivers seeking help, it is a step in the right direction. Dyadic Developmental Psychotherapy is not a coercive therapy as defined by the American Professional Society on the Abuse of Children (Chaffin, M., et. al., 2006). Dyadic Developmental Psychotherapy provides caregiver support as an integral part of its treatment methodologies. Dyadic Developmental Psychotherapy uses a multimodal approach based on sound empirical evidence, as the following paragraphs will describe.

Specific components, methods, and principles of Dyadic Developmental Psychotherapy that have good empirical support (Orlinsky, D., Grawe, K., Parks, B., 1994) include the following:

1. Affect arousal, a focus on problems of living and on core personal relationships are elements of Dyadic Developmental Psychotherapy that have been shown to be important for positive outcomes for treatment. Beutler, et. al., (2004) report that, "In recent years, there has been renewed emphasis on the role of emotional arousal in psychotherapy. Major reviews…conclude that interventions that provoke emotional arousal will increase positive outcomes" (p. 263.). At the same time, through the dyadic regulation of arousal as it emerges, the therapist using Dyadic Developmental Psychotherapy ensures that the child will not become over-aroused.
2. Explaining how the past may be continuing to effect present behavior and emotions, interpretation, has been found to be an effective mode of intervention in 63% of studies.
3. Forming and maintaining a therapeutic relationship is a core component of Dyadic Developmental Psychotherapy. The therapeutic alliance has been shown to be vital to successful treatment outcome (Lambert & Ogles, 2004; Norcross, 2001) The use of PACE is designed specifically to help facilitate this. There is a significant positive association between outcome and the therapeutic bond (66% of the studies with an effect size of at least .25 in one quarter of the studies (p.308)). In looking at the therapist's contribution to the therapeutic bond, a significant positive association with outcome was found. "The therapist's contribution was positively associated with outcome 67% of the time and never negatively implicated." (p. 321). "The strongest evidence linking process to outcome concerns the therapeutic bond or alliance." (p. 360).
4. Acceptance is a significant dimension of the practice of Dyadic Developmental Psychotherapy.

Therapist affirmation (acceptance, non-possessive warmth, or positive regard) was found to be a significant factor in positive therapeutic outcome. Acceptance involves an entirely nonjudgmental stance directed toward the thoughts, feelings, intentions, etc., that characterize the child's "inner life." Described differently, expressive attunement or the level of empathic understanding and personal rapport have a substantial history of having been shown to be important factors in positive outcome. There is now, "a general acceptance of empathy as a factor in outcome, which has been clearly confirmed again in a current meta-analysis," (Orlinsky, Ronnestad, & Willutzki, 2006, p. 350.)

5. Dyadic Developmental Psychotherapy has both cognitive and experiential dimensions. For both these dimensions there is a large body of support. "The existing research is now more than sufficient to warrant a possible valuation of experiential therapy in four important areas: depression, anxiety disorders, trauma, and marital problems, even using the strict version put forward by Chambles and Hollon (1998; the successor of the APA Division 12 Criteria)" (Elliott, Greenberg, Lietaer, (2004) p. 527.
6. Overall such factors as empathy, the capacity for reflection, intersubjective sharing of affect, awareness, and intention, the therapeutic alliance, furthering reflection, deepening emotional processing, enhancing adaptive skills, developing and maintaining the therapeutic bond, therapist affirmation, communication attunement, and the bond of relatedness between therapist and patient are all important factors in psychotherapy outcome and are all important elements of Dyadic Developmental Psychotherapy.

Relationship factors loom large as important for successful treatment outcome (Lambert & Ogles, 2004). It is these common factors across therapies that account for a significant portion of treatment outcome. "A therapeutic relationship that is characterized by trust, warmth, understanding, acceptance, kindness, and human wisdom," (Lambert & Ogles, 2004, p. 180), are described as a broad set of factors that are common across therapies and associated with patient improvement. These are the very same factors that form the core attitude of Dyadic Developmental Psychotherapy.

Dyadic Developmental Psychotherapy emphasizes the process of treatment and focuses extensively on the relationships among those involved in treatment.

## SUMMARY

Dyadic Developmental Psychotherapy is based on principles of treatment with strong empirical evidence. In addition, the treatment has been shown to be effective with a very difficult population, children who meet the DSM-IV criteria for Reactive Attachment Disorder. Dyadic Developmental Psychotherapy relies on well-known therapeutic principles and techniques that have proven effectiveness. It is a structured and systematic methodology for modeling the intersubjective and attuned sharing of experiences. Dyadic Developmental Psychotherapy involved the identification, regulation, and integration of parallel processes (parent-child, therapist-parent, and therapist-child) in a manner that changes the parent so that the parent becomes a more secure base for the child that helps the child acquire greater security. The well- established history of these interventions, combined with recent specific empirical outcome studies of Dyadic Developmental Psychotherapy offers strong support for the efficacy of this treatment modality.

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