Dyadic Developmental Psychotherapy (DDP) Level 2
7th – 10th November 2017
Nottingham, UK

I would like to firstly thank the FPSA for their generous funding to complete the level 2 training in DDP. The course was a 4-day programme, for those who had completed the level 1 training. It was led by Dr Susan Drake who has a Clinical Psychology background, yet also a Consultant in DDP and accredited trainer. I will avoid repeating previous reports in providing detail on the clinical approach of DDP, yet will describe how the new learning has impacted on my practice in working with adolescents in a Child and Adolescent Mental Health Service (CAMHS).

I currently work in a CAMHS and my role includes clinical interventions for young people with high risk and/or significant mental health difficulties, specialist neurodevelopmental assessments and supervision/consultation to members of the multi-disciplinary team. Many of the young people I work with have a trauma history and subsequent attachment difficulties and are referred to CAMHS due to the high risk behaviours they display. Despite DDP being initially developed for young people most often seen in a LAC setting, due to being abused and removed from their birth parents, and therefore many of the case examples illustrate collaborative work with foster carers and 'new' caregivers, it is a model that I have found can be applied to all aspects of work with young people presenting with attachment difficulties and their families.

Prior to the course, we were encouraged to bring video tapes of clinical sessions where we had been using DDP as an approach, so that we could receive live supervision from the trainer, though this was not compulsory. It was a shame that no one was able to bring in any footage to share and so the live supervision was provided following role plays on how to improve our practice and further our reflections of the implementation of the 'PACE' model. However, Susan was able to play several clips of video footage of her clinical practice which was invaluable; not just as a demonstration of the techniques and methodology we were learning about, but also how to "repair" if a rupture occurred in the therapeutic alliance. I found this particularly validating, because it provides a space to think about how therapists might not always get things 'right' and what they can do if they feel the reflective dialogue with the young person and/or carer is not as effective as it could be or has been perhaps unhelpful. The training also included new learning in relation to advances within the fields of Neuroscience and how this has strengthened the evidence-base for the effectiveness of using DDP which was incredibly thought-provoking.

We shared our own attachment histories in small groups which I found to be a really powerful exercise, not only in building trust and 'togetherness' with peers on the course, but also in providing me space to reflect on my own experiences and how this may impact on myself as a therapist. It reminded me of the importance of self-reflexivity when often this is not prioritised in a busy working climate focussing on service cost-effectiveness and performance targets.

Completion of this training has enabled me to start to reflect on my clinical work using this model and implement the approach with young people who present with a trauma history and with parents/carers who are motivated to increase understanding of their child and adjust the way in which they offer care. I am passionate about this approach and have seen the positive impact it can have with the young people, carers and professionals that we work with. I have presented an overview of the training and approach to my CAMHS colleagues and have encouraged others to access DDP resources and attend future trainings and am liaising with service managers about the therapeutic benefits of offering this model in CAMHS as it is such a flexible tool to have. I plan to work towards accreditation, although this currently presents as a challenge because the CAMHS service I work in doesn't fully recognise DDP within its current intervention pathway structures.

Instead, I plan to seek accreditation from supervision of my private practice with young people and their families which I hope to further develop over the next 12 months and continue my conversations with service managers about the benefits of this approach.

Once again, I'd like to sincerely thank the FPSA for their support in me accessing this training and acquiring further skills in this area with the aim of working with vulnerable young people with the goal of eliciting positive change and a better quality of life for them and their families.

Dr Caroline Falconer
Senior Clinical Psychologist
Leeds CAMHS