Working with vulnerable youth: Attachment, trauma & risk

Developing a framework for supporting Young People with Complex Presentations

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Introductions

- Introductions
- Timings

- PART 1: Who and what risks?
- PART 2: Brain Development
- PART 3: Attachment
- PART 4: Impact of Trauma
- PART 5: Implementing into Practice – some ideas
- PART 6: Case study

Aims / Learning Outcomes

- To review and understand the principles of brain development, attachment theory and human development
- To increase awareness of complex trauma and its impact on young people and high risk behaviour
- To explore pragmatic ideas for how an understanding of attachment and trauma can help our everyday practice
- To explore ideas and principles for intervention
- To promote reflective practice
- To raise awareness of the impact of 'ourselves' on our practice

Health Warning

- The first principle of supporting others is that you need to care for yourself first!
- LOOK AFTER YOURSELVES

PART 1: WHO & WHAT RISKS?

"OMG…s/he is so, so, risky!"

What might they do?

Violence

Food based difficulties

Disgust / Self-neglect

Absconding (Exploitation/ Victimisation)

Fire-setting

Sexually Harmful Behaviour

Suicide & Self-Harm

The harsh reality: harm to others

Harm to self and suicide

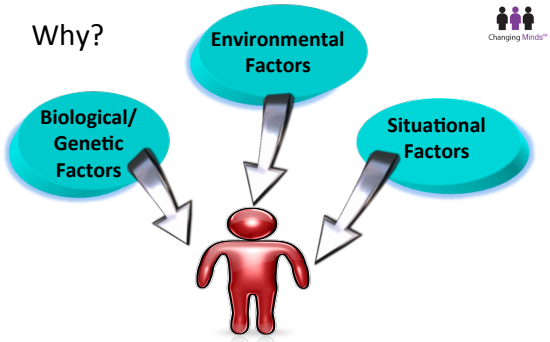
Risk from others – Exploitation and Victimisation

- Childhood Sexual Exploitation
- Extremism
- Gangs
- …..grooming
- Bullying / Abuse

Worksheet:

- Think about a young person you have or are working with……..
- Section 1: What are the 3 main/highest risk concerns you have about the young person?

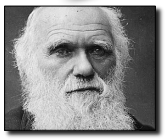
Why?



Decision Theory: The proximal cause is a decision to act

Common Features….

"It's not the strongest of the species that survive, nor the most intelligent, but the most responsive to change."



Megginson, 'Lessons from Europe for American Business', Southwestern Social Science Quarterly(1963) 44(1): 3-13, at p. 4.

Some Key Assumptions

- Nature/nurture debate defunct
- Brain development starts before birth – born unfinished
- **Babies are born 'dysregulated' (egocentric, behaviourally disinhibited & without empathy!)**
- Our genes are influenced by our environment during pregnancy and well into the first years of life
- We (parents, culture, society) teach babies what they feel & how to relate – including their language
- These experiences can influence at a biological level
- Brain development continues into young adult life (Blakemore 2006 & 2010)
- The way you spend your time shapes your brain
- **Young people adapt to their environment with survival as the primary goal**
- **Developmental perspective is paramount across the lifespan**

Key points

- Key question: How has this client (and their brain) adapted to survive in their environment? – maximise care / stay safe
- 2 underlying processes:
  - Attachment style (working model) & emotional regulation
  - Alarm & trauma response system
- For many [most] YP who display high risk behaviours:
  - Disrupted attachment experiences
  - Repeated trauma (t & T)

Attachment, trauma & brain development

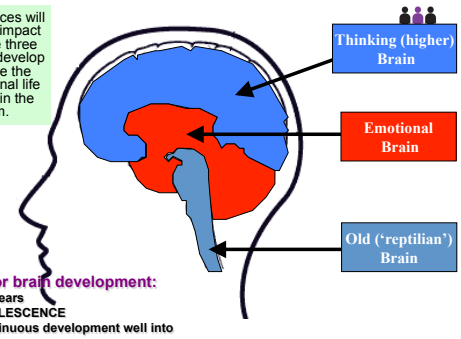
PART 2: BRAIN DEVELOPMENT

Regions of the Brain

BRAIN QUIZ

Evolution of the brain

Early experiences will have a major impact on how these three brain regions develop and influence the child's emotional life & behaviour in the long-term.

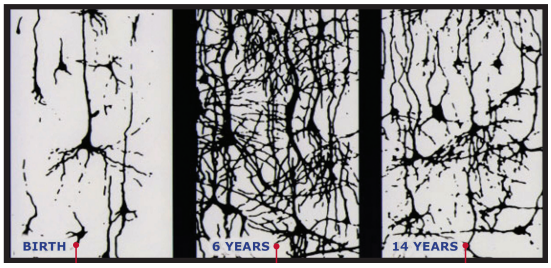


Key times for brain development:

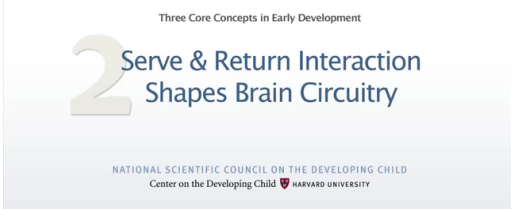
- 0-2 years
- ADOLESCENCE
- Continuous development well into 20's

The developing brain

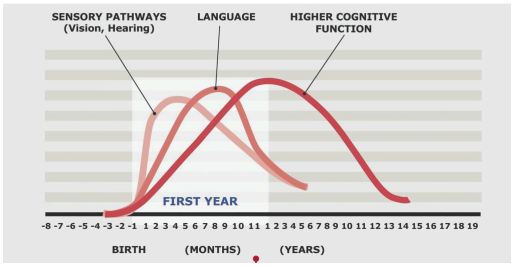
Experience Shapes Brain Architecture by Over-Production of Connections Followed by Pruning



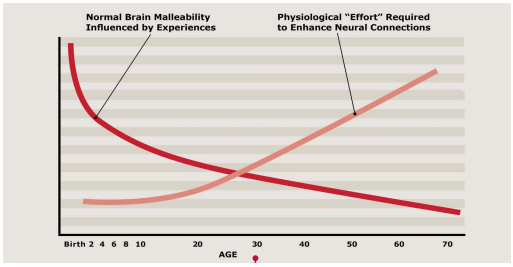
The developing brain



Brains Are Built from the Bottom Up: Skills Beget Skills



The Ability to Change Brains and Behavior Decreases Over Time



Adolescent brain development

- Areas of the brain mature at different rates
- The ability to automatically see things from another person's point of view is still developing
- Developmental mismatch between parts of the brain that process emotional and reward signals and those that regulate these responses
- The adolescent brain is like a "fast car with poor brakes"

Exercise: Typical Development

- What experiences do children need to help positive brain development?

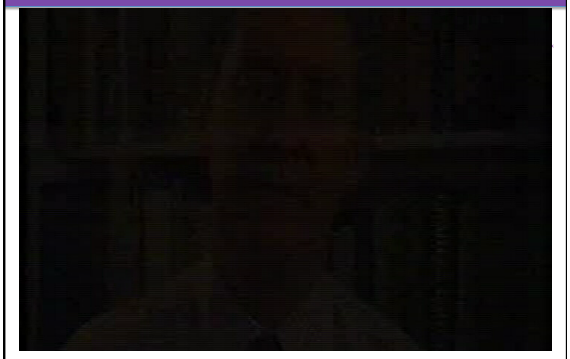
Examples of developmental experiences that promote well-being

- Secure attachment
- Authoritative (balanced) parenting – firm, but fair
- Realistic developmental expectations
- Stable and supportive family environment
- Good communication
- Good social support & positive relationships
- Multiple interests / hobbies
- Physical well-being
- Pro-social peers
- **Developmentally appropriate exposure to risk**
- Achievement

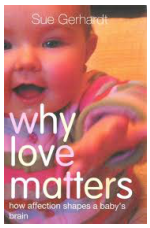
The developing brain

Worksheet:

- Think about the young person you have identified……..
- Section 2: What early experiences have they had that may be relevant to their presentation?



"Deficits in cortical functions result in poorer problem-solving, and impoverished capacity for empathy. Such children become the delinquents and psychopaths of the future" *(Gerhardt et al., 2004).*



PART 3: ATTACHMENT

Exercise: What is attachment?

- Mind dump

What is Attachment?

"Viewed properly, attachment is the very foundation for a child's ability to understand and participate in the extended social and cultural world without undue emotional conflict"

Grossmann (1995)

Attachment as foundation….

- Understanding own and others behaviour and emotional experience (e.g. a sense of empathy)
- Understanding own worthiness (e.g. self esteem)
- Recognising emotional availability of others and their ability to provide a 'safe' environment
- **The ability to recognise and regulate emotion**
- Social and moral development

In the beginning……

- Bowlby's findings:
  - Negative behavioural, emotional & mental health outcomes of children separated from parents or who suffered emotional adversity in childhood
  - Young children separated from their mothers experience a recognisable sequence of distressed behaviours (Robertson & Bowlby, 1952)

What is attachment…

- Attachment is an ***adaptive*** evolutionary process and a means of survival
- Involves seeking proximity to the primary caregiver when a child experiences distress/discomfort/need
- **The response of the caregiver helps the child develop a mental 'model' of themselves, others and the world (relationships)**
- This impacts at a genetic and biological (brain) level

"Both the quality of care and security of attachment affect children's later capacity of empathy, emotional regulation, cognitive development and behavioural control" *(Kestenbaum et al, 1989)*

Attachment behaviour

- Adaptive behaviour that is activated when emotional regulation system overwhelmed – seek proximity
- Behaviours that generate emotion in carers or significant others
- 3 categories *(Belsky & Cassidy, 1994)*:
  - Socially appealing - Signalling (e.g. smiling, verbalising) (mother→child)
  - Distress signals - Aversive / high risk (e.g crying, disgust behaviours) (mother→child)
  - Active approach (child→mother)
- Are recognised throughout the lifespan when requiring emotional support

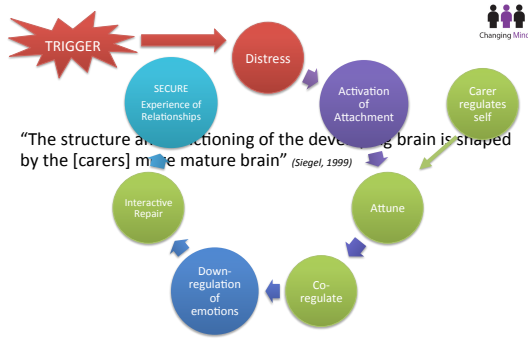
Attachment Behaviours as 'risk' behaviours

Table 15.1 High-risk attachment behaviours

Risk to self	Risk to others
1. Self-harm (inc. alcohol/substance misuse)	4. Violence
2. Food-based difficulties (inc. restricting food/overeating)	5. 'Disgust' behaviours (inc. spitting, smearing, urinating, poor self-care)
3. Absconding (increasing vulnerability and increased risk from others)	6. Fire-setting
	7. Sexually harmful behaviour
	8. Frequent and unsubstantiated complaints

"A baby alone does not exist" *(Winnicott, 1965)*

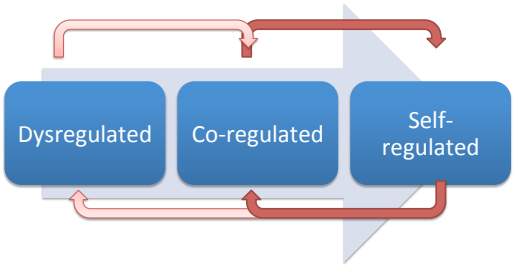
The Process of Secure 'good enough' Attachment.....



"The structure a... ctioning of the deve... g brain is shaped by the [carers] m... e mature brain" *(Siegel, 1999)*

Adapted from Fonagy, P www.ucl.ac.uk/psychoanalysis/unit-staff/mbt_training_theory.pdf

Developmental process



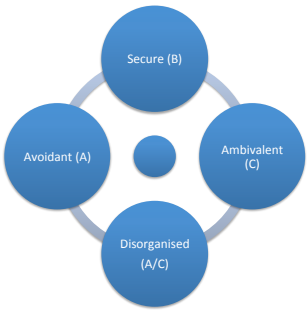
Secure Attachment

- "The secure child [adult] has the psychological and neurological capacity to self-modulate recognised affects" *(Schore, 2001)*
- More curious, competent, empathic, resilient, self-confident, get along better with other children, more likely to form close friendships
- Better able to resolve conflicts
- Seek help appropriately
- **Lower risk of offending [high risk] behaviour and MH difficulties**

The Strange Situation (Ainsworth) - Secure Attachment

Atypical development

- If processes of attunement / co-regulation and interactive repair are (dys)functional.....
- E.g if a child's distress is often indulged (over-care), ignored or responded to with inconsistency, anger, anxiety, their brain is likely to develop differently.....
- → Insecure (but adaptive) attachment patterns



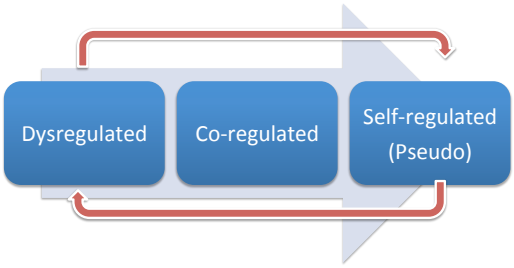
Strange Situation – Insecure-avoidant

Insecure – Avoidant -Type A

Self: unloved, self-reliant
Others: rejecting, controlling, intrusive

- Linked to neglect / emotionally supressed / overbearing environments
- Less access to painful memories (Belsky, 2002)
- Avoid intimacy, dependence and disclosure
- Hard to engage
- Often don't experience a huge need for other people
- Seen as 'cold' – often described as 'lacking empathy and remorse'
- Linked with higher incidence of physical illness (somatising) and hard drug use
- **Rely strongly on cognitive information (to distance from emotion)**
- **False affect** (often masked depression/PTS symptoms)
- **Dysregulated – but supressed**: Bottle, bottle, bang!
- Link with higher frequency of PTSD
- ? At extremes + trauma = Conduct disorder → ASPD
- ASPD is more frequently observed in those with a history of physical abuse/neglect (De Bellis, 2005; Johnson, et al., 1999, Walker et al., 1999)

Avoidant (extreme)



Strategies – Avoidant

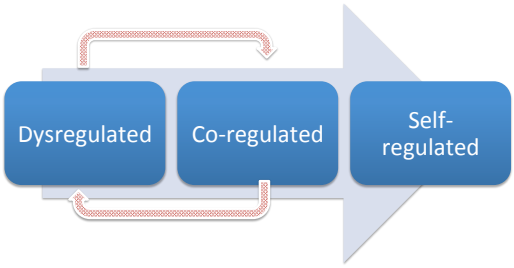
- Emotion focused – but subtle
- Model appropriate help-seeking / sharing of emotion
- Be aware of potential 'hidden feeling' but……
- Don't 'chase' emotion
- Just 'be' – less 'do'
- Little things matter – notice asking for help
- Just asking 'how are you doing' – little and often
- Resist the temptation to feel rejected / Don't expect instant positive feedback

Insecure-Ambivalent – Type C

Self: low value, ineffective, dependent
Others: insensitive, unpredictable, unreliable

- Focus on own distress & ruminate on it: Overwhelming level of arousal that is difficult to self-regulate.
- Often described: Disruptive, 'attention seeking' and difficult to manage; insecure and coercive E.g. Coercive-aggressive pattern
- Can alternate between friendly charm and hostile aggression.
- Display highly dysregulated behaviour, impulsivity, poor concentration
- Feel a growing sense of unfairness and injustice – lots of complaining
- Easy access to painful memories (Belsky, 2002)
- Increased incidence of mood disorder
- Cognitive information/skills discounted
- Driven by affect – it's all about emotion and you get what you see! - **DYSREGULATED & overt!**
- ? At extremes + trauma = Reactive Mood & dysregulated → BPD

Ambivalent (extreme)



Strategies - Ambivalent

- Pre-empt:
  - 'Drama' – safety planning
  - Perceived rejection / inconsistency
  - Splitting and conflict in support team
- Firm, but fair – 'tread the middle path'
- Always validate emotion first – then focus on problem solving
- Consistent, coordinated 'care'
- Structured, consistent 'attention' – beginning, middle and end of day

A/C or 'Disorganised'

If only it were that simple……..

Multiple strategies – threat/environment specific…….

- Experience carers as threatening: 'scaregivers'
- ?…..A/C model – use avoidant and ambivalent strategies at extremes dependent on nature of threat
- ? Developmental pathway: Avoidant → Ambivalent → Secure ????

Exercise: Pen Portraits

- Individual – Pen Portraits

Worksheet:

- Think about the young person you have identified……..
- Section 3:
  - What may be the dominant adaptive attachment strategy?
  - How may they have learned to think about themselves / others and the world?

Attachment and Trauma

- Attachment disruption can mean a child is vulnerable to experiencing problematic trauma reactions
- Young people who have a disrupted attachment experience may well then experience more trauma if they remain in the same caregiving environment

PART 4: THE IMPACT OF TRAUMA

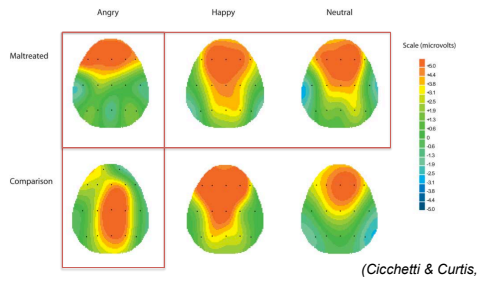
T & cumulative 't'

- *"Children are much more vulnerable* [to traumatic experience]. *They have fewer resources and are much closer to the possibility of death. Experiences that may not be a matter of life and death for an adult may well be experienced as such by a child"* (*Gerhardt, 2004*, p.143)
- E.g. repeated separation, 'put-downs', rejection, prolonged shame – as well as T trauma.

Attachment / trauma and effects on the developing brain

- Early experiences of disrupted attachment and 'trauma' (T and t) underpin:
  - Our sensitivity to stress/threat
  - Our ability to process/interpret social information
  - Our ability to empathise with others
  - Our ability to regulate emotions
  - Our capacity to seek support and comfort (co-regulation)

Facial Recognition

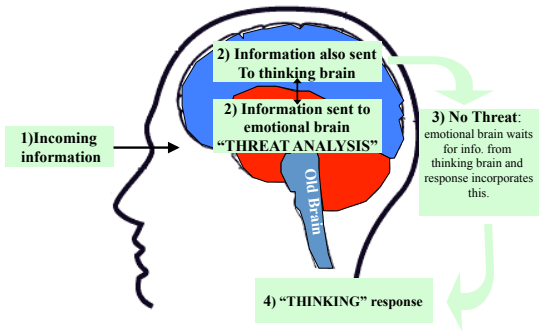


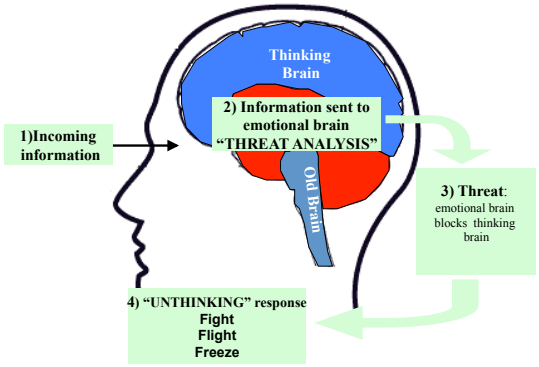
(Cicchetti & Curtis, 2005)

Impact of Trauma & Maltreatment

- Impacts on brain function / development *(e.g amygdala size)*
- Impact on brain (structural, functional & behavioural) worsens the longer the duration of trauma *(De Bellis & Kuchibhatla, 2006)*
- High arousal places stress on attachment model / emotional regulation system
- The compulsion to re-enact (Van der Kolk, 1989)
  - Re-enactment/re-experiencing/re-telling can increase arousal, **BUT can have a counter-intuitive 'soothing' effect**
  - C.f. YP who only seem to talk about violence/violent re-enactment - can be misinterpreted as enjoying it
  - DANGER of direct focus on trauma, without effective regulatory systems - Trauma memory does not get processed, just reinforced!

- *"Those whose internal systems are less robust because of their early experiences* [of attachment disruption and trauma] *may simply be more vulnerable to adversity and less able to draw on the powers of their frontal cortex* [to process distress and regulate emotion and behaviour]" *(Gerhardt, 2004)*





Luke & Johnny

Worksheet:

- Think about the young person you have identified……..
- Section 4:
  - What feelings may be 'hidden' or expressed?
  - How do they manage these emotions?

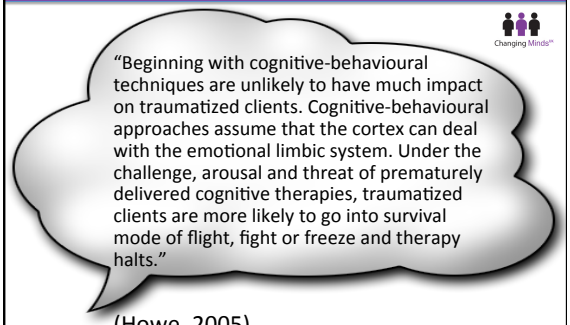
PART 5: IMPLEMENTING INTO PRACTICE – WHAT DO WE DO?

Learning

- **Stability of placement and relationships are paramount**
- There's not an easy answer as to 'what helps'
- No diagnosis, single model, therapy or way of understanding is 'the answer' – **multi-systemic/multi-factorial**
- Be aware of parallel process and vicarious trauma
- Getting the day to day care 'right' should be the basis of any intervention and the primary focus of support
- Interventions should start where the child is at - developmental
- Every interaction matters! – we are all 'therapists'
- Carer is the 'expert' about the child – professionals are supporters/ advisors

Misplaced therapy – therapy without the system

- *'Too narrow a focus on individual therapy can lead to an expectation that children will adjust to a world for which they are not equipped. The therapy becomes a way of 'making children fit'* *(Golding, 2006, p306).*
- *'Is it not arrogant to believe that one hour a week spent with a young person is the primary facilitator of change, when they have spent the other 167 hours with other people?'* *(Rogers, Law & McMahon, 2011).*



(Howe, 2005)

What do we know about traditional individual therapy?

- **Individual therapy can be a very powerful and positive tool (although relatively small evidence-base for children)**
- Children are not 'mini-adults' – therefore the same assumptions about effectiveness of therapy do not apply
- Therapy can be harmful - Across all therapies (mainly adult research) approx. 12% get worse
- Publication bias towards 'success' – avoidance of 'not knowing'/making mistakes/vulnerability by professionals

What do we know about traditional individual therapy?

- Client choice - Children rarely refer themselves – rather initial contact is usually due to an anxiety in the care system
- Adolescents often report that 1:1 therapy in a clinic can be experienced as intrusive, boring, unhelpful.
- Post-therapy session behaviour can be extremely disruptive => placement breakdown
- Much therapy is instigated based on 'problem' rather than psychological assessment and formulation
- Often individual therapy is not delivered within a clear outcomes framework → excuses for poor outcomes: did not engage, did not turn up, external factors

? Mis-matched therapy

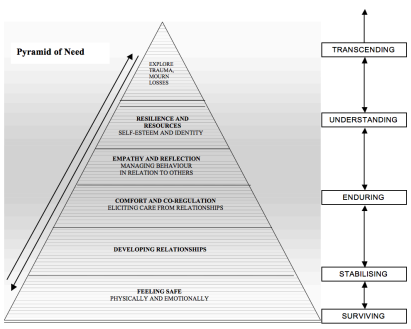
- Avoidant – skills based/CBT e.g. anger management, thinking skills/problem-solving, worksheets
- Ambivalent – emotion focused/unstructured/ exploratory e.g. psychodynamic, 'counselling',
- Trauma + (poor emotional regulation): 'exploratory', Life story

Therapy Considerations

- Therapy is not a neutral intervention – it is rarely the primary solution!
- Any **formal** 1:1 therapy (including formalised life story intervention) should only be considered after a thorough assessment, drawing on multiple models of understanding and driven by a clear psychological formulation of needs
  - Developmental stage
  - Trauma
  - Attachment
- Number of attachment relationships
- Pace, timing, dosage, modality
- Always should have clear goals and outcomes are monitored – be brave and willing to acknowledge when it is not working!

Therapy in everyday interaction

- **Every** interaction with a client with complex attachment/ trauma presentation is likely to activate attachment system
- Therefore **every** interaction has the potential to be therapeutic (or harmful!!)
- Attune, co-regulate, interactive repair
- Observe & assess properly for trauma – 'false affect'!
- Important to retain a 'mentalizing' stance
  - Awareness of self
  - **Curiosity**
  - Non-judgemental (genuinely interested in understanding what's going on)
  - Understanding the misunderstanding
  - It's ok to say sorry, to reflect confusion, to get it wrong – it's how you manage this that is the key!



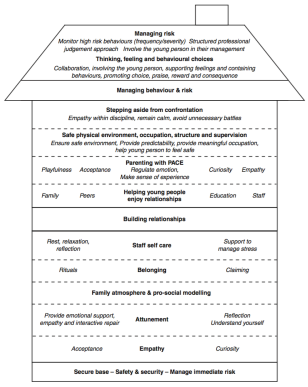


Figure 15.1 The DART house of parenting

Aims of this whole-systems approach

1. Reduce the severity and frequency of high-risk behaviours and promote safety
2. To raise caregiver sensitivity through understanding complex presentations
3. Facilitate emotional regulation
4. Facilitate self-regulation of behaviour
5. Promote prosocial relationships with staff & peers
6. Reduce placement moves
7. To address the needs of young people who are 'at risk' of developing more chronic and enduring mental health problems
8. Pathway approach based on supporting and building adaptive development

Staff Self-Care

- High-risk behaviour generates high levels of emotion in others
- The emotional well-being of staff is an essential ingredient to successful outcomes
- Staff need to feel safe and work from a regulated position in order to regulate and inform the emotional tone of the environment
- **Team support is vital, as is supervision and consultation**
- There is a need for rest & relaxation
- Beware of traumatised systems!

Intervention Planning

- Creating safety (through **relationships**)
- Managing risk & identifying intervention goals (using SPJ / **formulation)**
- Getting the timing right (**developmentally attuned**)
- Choosing the right therapeutic approach (using our understanding of **attachment strategies**)
- Get the dose & pace right (considering **trauma and shame**)
- Being accountable (**monitoring outcomes**)

PART 6: CASE EXAMPLE

Worksheet:

- Think about the young person you have identified……..
- Section 5:
  - What triggers are there to the behaviour?
  - What thoughts and feelings may the young person have in the short-term when displaying these behaviours?
  - What tend to be the long-term consequences of the behaviour?

Challenges

- VICARIOUS TRAUMA & PARALLEL PROCESS
- Negative attitudes: "difficult/bad/challenging/damaged"
- Maintaining realistic expectations & 'real-life' outcomes vs fantasy
- System pressure:
  - To be seen to be 'doing' something
  - to segregate &/or to 'socialise'
  - to focus intervention on offence
  - for individual 'therapy'
- High system anxiety
  - dysregulation in us ('parents') → less than optimal 'parenting' & decision making
  - Paralyses ability to mentalize (Fonagy, 2006), attune & co-regulate (with each other as well as our clients)
  - Increases system fight/flight/freeze response
- Replicating past relationship patterns – neglecting/rejecting/hostile/fearful/ ambivalent/avoidant
- Managing high risk behaviour
- Care vs control

Basic Ideas / Complex Delivery

- Use multiple perspectives, psychologically informed approaches to providing developmentally appropriate care:
  - Unless we recognise adaptive attachment processes & address the 'gaps' in the developmental process
  - Unlikely to impact long-term on brain development, regulatory system & nurture more typical developmental processes
  - Unlikely to have prepared the YP for the emotional challenges of effectively processing traumatic memories
  - Unlikely to fundamentally change behaviour/compulsion to re-enact
  - Unlikely to manage risk effectively
  - Likely to be treatment resistant esp. to 'cognitively' based interventions

Basic Ideas / Complex Delivery

- Risk behaviours → Attachment behaviours
- Avoid 'recreating' earlier maladaptive attachment experiences
- **PRIMARY INTERVENTION MUST BE WITH CARE-GIVER(s)** (Family/ YOT worker/social worker/Prison officer/MH Nurse)
- …….only then add specialist 'technologies' / offence-focused intervention
- 'Good enough' – long-term approach
- Dosage/frequency/timing – important considerations
- **Emotionally attuned & regulated systems → emotionally attuned and regulated people**
- **REAL LIFE EVALUATION**
- Emotional & Mental health is **everyone's** business

Basic Ideas / Complex Delivery

- **Young people are not 'mini-adults'**
- Formulation (& intervention) **must** include reference to early developmental pathway
- START WHERE THEY ARE AT!
- Use knowledge of attachment/trauma/child development (even if they are over 18!)
- **Treatment needs to incorporate intervention strategies that promote a return to 'typical' development and engagement with age-appropriate activities** ***(Marmar, Foy, Kagan & Pynoos, 1993).***

Intervention Planning

- Creating safety (through **relationships**)
- Managing risk & identifying intervention goals (using SPJ / **formulation)**
- Getting the timing right (**developmentally attuned**)
- Choosing the right therapeutic approach (using our understanding of **attachment strategies**)
- Get the dose & pace right (considering **trauma and shame**)
- Being accountable (**monitoring outcomes**)

Evaluation

- Please fill out the evaluation forms and thank you for your attendance
- Email: admin@changingmindsuk.com

THANK YOU

Selected References

- Abram, K.M, Teplin, L.A., Charles, D.R., Longworth, S.L., McClelland, G.M., Dulcan, M.K. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. Archives of General Psychiatry 61: 403–410.
- Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978) *Patterns of Attachment: A Psychological Study of the Strange Situation*. Hillsdale, NJ: Lawrence Erlbaum Associates Inc.
- Allen, J. (2001). *Traumatic relationships and Serious Mental Disorders*, Chichester: Wiley.
- Belsky, J., and Cassidy, J. (1994) Attachment: Theory and Evidence. In *Development Through Life: A Hand-book for Clinicians*, Rutter, M. and Hay, D. eds. Pp. 373-402. Oxford: Blackwell.
- Blakemore, S-J. (2006). Development of the adolescent brain: implications for executive function and social cognition. Journal of Child Psychology and Psychiatry. 47, 3-4, 226-312.
- Blakemore, S-J. (2010). The Developing Social Brain: Implications for Education. Neuron 65, March 25.
- *Bloom, S. L. (1999). "Trauma Theory Abbreviated." Philadelphia, 1999. Community Works. <http:// www.sanctuaryweb.com >.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.*New York: Basic Books.
- Briere, J. & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment.* Thousand Oaks, CA: Sage Publications.
- Cicchetti, D & Cook, W.J. (2005). An event-related potential study of the processing of affective facial expressions in young children who experienced maltreatment during the first year of life. *Development & Psychopathology* 17: 641-677.
- *Cook, A.; Spinazzola, J.; Ford, J.; Lanktree, C.; Blaustein, M.; Cloitre,M.; DeRosa, R.; Hubbard, R.; Kagan, J.; Mallah, K.; Olafson, E. & Van der Kolk (2005) Complex Trauma in Children & Adolescents. *Psychiatric Annals*, 390-398.
- Crittenden, P. M. (2005). Teoria dell'attaccamento, psicopatologia e psicoterapia: L'approccio dinamico maturativo. Psicoterapia, 30, 171-182.
- Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, **99**, 20-35.

Selected References

- Freud, S. (1914). Remembering, Repeating and Working-Through (Further Recommendations on the Technique of Psycho-Analysis II). The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (1911-1913): The Case of Schreber, Papers on Technique and Other Works, 145-156
- Freud, S. (1920). Beyond the Pleasure Principle. The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XVIII (1920-1922): Beyond the Pleasure Principle, Group Psychology and Other Works, 1-64
- Gerhart, S. (2004) *Why love matters: How affection shapes a baby's brain.* London: Routledge.
- *Golding, K., Dent, H.R., Nissim, R., & Stott, E. (2006) *Thinking Psychologically about Children who are Looked After and Adopted: Space for Reflection.* Chichester: Wiley.
- *Golding, K. S. (2008) *Nurturing Attachments. Supporting children who are fostered or adopted.* London: Jessica Kingsley Publishers.
- Holmes, J. (2001). *The Search for the Secure Base: Attachment Theroy and Psychotherapy.* London: Brunner-Routledge
- Hughes D. A. (2004) An attachment-based treatment of maltreated children and young people. Attachment & Human Development, 6,3, 263-278.
- Hughes D.A (2006) *Building the bonds of attachment. Awakening love in deeply troubled children.* Aronson,. 2nd Edition.
- Pelcovitz, D., Van der Kolk, B. A., Roth, S. H., Mandel, F., Kaplan, S. & Resick, P. (1997) Development of a criteria set and a structured interview for disorders of extreme stress. *Journal of traumatic stress*, **10**, 3 -16.
- *Perry, B. D. (2000). Traumatized children: How childhood trauma influences brain development. *The Journal of the California Alliance for the Mentally Ill 11*(1), 48-51

Selected References

- Perry, B. D. (2006) Applying principles of neurodevelopment to clinical work with maltreated and traumatized children. The neurosequential model of therapeutics. In Webb, N. B. (ed) Working with traumatized youth in child welfare. Chapter 3, Pp 27-52. NY: The Guilford Press.
- Rogers, A D. & Law, H. (2010). Working with Trauma in a Prison Setting in Harvey, J. & Smedley, K (Eds.) *Psychological Therapy in Prisons and other Secure Settings*. London: Willan Publishing
- ***Saxe, G.N., Ellis, B.H & Kaplow, J.B. (2007) *Colaborative Treatment of Traumatized Children and Teens: The Trauma Systems Theory Approach. London*: Guilford Press.**
- Schore, A.N. (2001). The effects of a secure attachment on right brain development, affect regulation, and infant mental health. Infant Mental Health Journal, Vol. 22(1-2), 7-66.
- Schore, A. (2003) Affect Dysregulation and Disorders of the Self. New York: Norton.
- Schore, J. R. & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. Clinical Social Work Journal, 36, 9-20. doi: 10.1007/s10615-007-0111-7
- Sunderland, M. (2006) The science of parenting. London: Dorling Kindersley.
- Teicher, M.D. (2000). Wounds that time won't heal: The neurobiology of child abuse. *Cerebrum: The Dana Forum on brain science, 2(4)*, 50-67.
- **Van der Kolk, B.A., (1989) The Compulsion to Repeat the Trauma: Re-enactment, Revictimization, and Masochism. *Psychiatric Clinics of North America*, Volume 12, Number 2, Pages 389-411. Retrieved from http://www.cirp.org/library/psych/vanderkolk/
- Van der Kolk, B.A., & Ducey, C.P. (1989). The psychological processing of traumatic experience: Rorschach patterns in PTSD. *Journal of Traumatic Stress*. 2, 259-274
- **Van der Kolk, B. A. (2005). Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401-408.