Working with High Risk Adolescents from A Developmental Trauma Perspective: Ideas and Emerging Practice

Developing the Therapeutic Rationale: Willow Unit & The Hindley Approach

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Setting the Scene – some observations

- Experience of 3 systems: Social Care/Mental Health/Criminal Justice System
- Community CAMHS/YOT/LAC Residential/Courts/Secure welfare/Inpatient MH/Prison (LASCH, SCH, YOI)
- Same client group? Different ‘treatment’ systems? – or often cross-systems!
- Core group of young people with complex histories of survival, attachment disruption and trauma
- Present with high risk behaviours (to themselves and/or others)
Setting the Scene - some observations

- Challenge whole systems: Social Care/Education/CAMHS/CJS – YP get passed between and within
- Mental health services often operate at the periphery (untreatable/‘behavioural’/DNA)
- Majority of young people do not present with ‘mental illness’, or fit one diagnostic category, rather a complex mix:
  - ADHD/PTSD/ASD/LD/CD/BPD/ASPD/ATTACHMENT D & ? PSYCHOSIS!!
- Difficulties ‘(re)-emerge’, intensify or become less ‘tolerated’ in adolescence (yr 9!!) – c.f. attachment system
- But..difficulties often identifiable early (with hindsight?)
- Highly resource intensive, difficult to change, frustratingly similar outcomes
- ......? lack of underpinning therapeutic rationale, psychologically driven formulation & intervention
Theoretical underpinnings – ‘Meta’-perspectives

- Not suggesting anything particularly NEW...
- *Attachment theory – Bowlby
- *Dynamic Maturational Model of Attachment and Adaptation (DMM)-Crittenden
- *Trauma theory (ies) – Van der Kolk, Briere
- Cognitive Neurosciences
- Systemic
- Behavioural
- Evolutionary/Biological.......  
- Key is integrating theories and operationalising into practice....
Key points

- Key question: How has this YP adapted to survive in their environment? – maximise care / stay safe

- 2 underlying processes:
  - Attachment style (working model)
  - Alarm/emotional regulation/trauma response system

- For many YP in CJS:
  - Disrupted attachment experiences
  - Repeated trauma (t & T)
Some Key Assumptions

- Nature/nurture debate defunct
- Attachment and brain development starts before birth
- Our genes are influenced by our environment well into the first years of life (Shore)
- Babies are born ‘dysregulated’ (egocentric, without empathy & violent!)
- We (parents, culture, society) teach babies what they feel & how to relate – including their language
- Important attachment processes of attunement, co-regulation and interactive repair → working models / ? schema of self, others & the world
- These experiences manifests at a biological level (brain structure & function e.g. amygdala, OFC)
- Young people adapt to their environment with survival as the primary goal
- Young people develop highly adaptive strategies to achieve this goal
- **Developmental perspective is paramount**
Evolution of the brain

Parenting will have a major impact on how these three brain regions influence the child’s emotional life in the long-term.

Key times for brain development:
- 0-2 years
- ADOLESCENCE
- Continuous development into late 20’s
Typical development – Attunement / Co-regulation & Interactive Repair

- **Attunement** – recognising emotional need of young person and responding to their emotional state.
  - develop an awareness that he/she is being noticed.
  - feel a sense of worth.
  - feel understood.
  - build a coherent & positive sense of self
  - integrate thoughts and feelings.
  - increase self-reflection and understanding.
  - develop skills in emotion recognition and regulation
  - improve communication skills.
  - develop empathy for others

- **Co-regulation** – parent regulates own emotional arousal and uses this to soothe and regulate distress of child

- **Interactive repair** - re-establishing an attuned relationship after a conflict/break: key therapeutic opportunity
Atypical development

- If processes of attunement / co-regulation and interactive repair are (dys)functional....... 
- E.g if a child’s distress is often ignored or responded to with inconsistency, anger, anxiety, their brain is likely to develop differently.........
Styles of Attachment

- Secure
- Insecure-Avoidant
- Insecure-Ambivalent (Ainsworth et al., 1978)
- Disorganised (Main & Solomon, 1986)
Insecure - Avoidant attached adolescents – Type A

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

- Avoid intimacy, dependence and disclosure
- Hard to engage
- View relationships as not important
- Don’t feel a huge need for other people
- Seen as ‘cold’ – reported (often falsely) as ‘lacking empathy and remorse’
- Are indifferent to other’s views – assume others dislike them
- Linked with higher incidence of physical illness (somatising) and hard drug use
- **Rely strongly on cognitive information**
- **False affect** (often masked depression/PTS symptoms) & **OVER-REGULATED**
- Bottle, bottle, bang!
- ? At extremes + trauma = Conduct disorder → ASPD
Insecure-Ambivalent attached adolescents – Type C

**Self:** low value, ineffective, dependent

**Others:** insensitive, unpredictable, unreliable

- Disruptive, ‘attention seeking’ and difficult to manage; insecure and coercive E.g. Coercive-aggressive pattern
- Can alternate between friendly charm and hostile aggression.
- Display antisocial behaviour, impulsivity, poor concentration
- Feel a growing sense of unfairness and injustice – lots of complaining
- Overwhelming level of arousal that is difficult to self-regulate.
- Increased incidence of mood disorder and borderline personality disorder
- Cognitive information/skills discounted
- Driven by affect – it’s all about emotion and you get what you see! - **DYSREGULATED**
- ? At extremes + trauma = Mood disorders & dysregulated → BPD
A/C & Disorganised

- If only it were that simple.........
  Multiple strategies – threat/environment specific....... 

- ? A/C at extremes, unresolved trauma (false affect, distorted cognition) and fully developed adult → Psychopathy 

- ?.....A/C model – use avoidant and ambivalent strategies at extremes dependent on nature of threat? 

- ? Developmental pathway: Avoidant → Ambivalent → Secure ????
Impact of Trauma

- Trauma – T & cumulative t
- Can impact on brain function / development (e.g. amygdala size)
- 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 ‘getting off’ on it or enjoying it. – ? lacking empathy/remorse
Developmental Trauma Disorder
(Van der Kolk, 2005)

A: Exposure
Multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma (e.g. abandonment, betrayal, physical assaults, sexual assaults, threats to bodily integrity, coercive practices, emotional abuse, witnessing violence and death). Subjective experience (e.g. rage, fear, defeat, resignation, shame).

B: Triggered pattern of repeated dysregulation in response to trauma cues
- Dysregulation (high or low) in presence of cues.
- Changes persist and do not return to baseline.
- Not reduced in intensity by conscious awareness.
- Affective
- Somatic (e.g. physiological, motoric, medical).
- Behavioural (e.g. re-enactment)
- Cognitive (e.g. thinking that it is happening again, confusion, dissociation, de-personalisation).
- Relational (e.g. clinging, oppositional, distrustful).
- Self-attribution (e.g. self-hate, blame).

C: Persistently Altered Attributions & Expectancies
- Negative self-attribution.
- Distrust of protective caregiver.
- Loss of expectancy of protection by others.
- Loss of trust in social agencies to protect.
- Lack of recourse to social justice/retribution.
- Inevitability of future victimisation.
Pyramid of Need (Golding, 2007)

- **Feeling Safe**
  - Physically and emotionally

- **Developing Relationships**

- **Comfort and Co-Regulation**
  - Eliciting care from relationships

- **Empathy and Reflection**
  - Managing behaviour in relation to others

- **Resilience and Resources**
  - Self-esteem and identity

- **Explore**
  - Trauma, mourn losses

- **Resilience and Resources**
  - Self-esteem and identity

- **Developing Relationships**

- **Feeling Safe**
  - Physically and emotionally
The Cornerstones of Recovery

Principle 1: Establish a safe, secure, predictable & nurturing environment

Principle 2: Frame the intervention in the context of the child’s relationship with attachment figures.

Principle 3: Key Developmental Tasks

Principle 4: Direct Trauma Work
Cornerstones of Recovery

Principle 1 - Establish a safe, secure, predictable and nurturing care giving environment for the child.

- Increasing external safety makes it possible to begin to address internal sources of danger. Including, unmanageable aggressive impulses, fears of abandonment and the defences used to cope with these internal states.
- Promote safety – not a SOFT approach - ? Conducive to secure settings?
- Maintain consistency – clear rewards/consequences (many of the rewards and consequences will be relationship based)
- **This is crucial before attempting any direct trauma work.**

Principle 2 - Frame the intervention in the context of the child’s relationship with attachment figures.

- Trauma affects expectations that adult carers will be effective protectors.
- **A major focus of therapy is to create feelings of closeness and intimacy between the child and the caregivers.**
- This helps the caregivers to attune to the child’s feelings and behaviour and to offer an appropriate level of containment during the therapy.
- Within the safe context of this relationship, the child should be encouraged to practice developmentally appropriate activities and routines, to strive for normative achievements and attempt new and adaptive ways of functioning.
The Cornerstones of Recovery
Principle 3: Focus on developmental tasks that have been disrupted by the traumatic experience.

- If the trauma occurs early in life, key developmental tasks can be disrupted including:
  - Establishment and consolidation of psychobiological rhythms
  - Recognition & regulation of emotions
  - Development of secure attachments
  - Balance between attachment and autonomy
  - Achievement of age-appropriate socialization skills
  - Readiness to explore the environment and learn

- Treatment needs to incorporate intervention strategies that promote a return to normal development and engagement with age-appropriate activities (Marmar, Foy, Kagan & Pynoos, 1993).

- This includes educating those who are working with the child about the impact of complex trauma and helping them to develop appropriate management strategies.
The Cornerstones of Recovery
Principle 4: Processing the Trauma Experience.

- 3 stage approach:
  - Psycho-education
  - Build resources
  - Address trauma memories (reprocessing)

- DANGER of direct focus on offence / trauma, without effective regulatory systems - Trauma memory does not get processed, just reinforced! – Harmful therapy
Why is this important in Forensic Settings?

- Many YP in CJS / Forensic settings have experiences of disrupted attachment & trauma
- Could be argued that many offences are committed as a result of fight/flight/freeze, re-enactment or ‘survival’ processes - particularly violent/sexual offences
- How does this fit with acquisitive offences / TWOC - Arousal level → self-soothing
- Many secure/prison settings struggle to manage/intervene effectively with highly challenging, reactive YP. → c.f incidents within prison, seclusion/separation & DPP
- Not great results so far – revolving door?
Intervention Approaches - Some ideas 1

- Unless we impact on the system/danger/environment for the YP, we are unlikely to see a change in adaptive functioning. If we put them back into the same environment/relational dynamics they will (re)-enact and (re)-adapt!

- Unless we recognise adaptive attachment processes and address the ‘gaps’ in the developmental process, we are unlikely to impact long-term on brain development, regulatory system & nurture more typical developmental processes – we are also unlikely to have prepared the YP for the emotional challenges of effectively processing traumatic memories.

- Unless we recognise and assess for trauma and its effects appropriately, we are in danger of re-traumatising and/or reinforcing the presentation (and also make it less likely the YP will engage in trauma treatment in the future).
Multi-disciplinary approaches informed by psychologically driven interventions are key

Do the basics first!

Care-giver relationships are paramount

PRIMARY INTERVENTION MUST BE WITH CARE-GIVER (Parent/YOT worker/social worker/Prison officer)

Re-create ‘typical’ parenting/developmental experiences: THERAPEUTIC PARENTING
  - Attunement
  - Co-regulation
  - Interactive repair

‘Good enough’ – long-term approach

Dosage/frequency/timing – important considerations
Intervention Approaches - Some ideas 3

Then consider supplementary interventions.....

- Crittenden: treatment guided by hypotheses regarding individual differences in self protection:
  - Danger & threat of danger
  - Self-protective strategies (attachment styles)
  - Information processing (e.g. Affect/cognition)

- A / C are psychological opposites – may require opposite interventions (DMM - Crittenden)

- Avoidant = over-regulated = false affect, reliant on cognition:
  - ? Don’t need more CBT!
  - Less structured approaches / more emotionally/affect focussed

- Ambivalent = dysregulated = ‘true’ affect, neglect cognition
  - cognitive approaches
  - regulatory skills/skills/skills

- Wrong intervention may reinforce difficulties
Challenges & Hopes

- Operationalising theory into practice with different environmental constraints
- Time & realistic expectations
- Dealing with the toxic nature – managing vicarious trauma
- Negative attitudes: “difficult/challenging/damaged”
- Getting drawn into their world
- Replicating past relationship patterns
- ‘Managing’ difficult/risky behaviour rather than effective interventions to tackle it

REALISTIC OPTIMISM: Adolescence is a huge window of opportunity e.g. Brain development, developmental tasks, unfinished models, receptive to change

- Aim to place alternative attachment models alongside other (mal)adaptive models
- Recognising the small steps..... setting your sights at an appropriate level
Willow Unit

- ‘Complex needs’ – those who present a challenge to typical prison regime
- 2 broad groups:
  - Community living (6) – Ambivalent/BPD
  - Intensive support (5) – Avoidant/CD & ASPD
  - Mental health (2) – (those waiting transfer to hospital – ‘mental illness’)
  - Initial assessment → formulation & care planning
- Weekly review meetings
- Generally runs as a typical prison ‘wing’, apart from...
- ‘Attachment/trauma’ meta-framework: Focus on attunement & responsivity as primary interventions
- In context of effective risk management
Willow Unit – Staffing

- Staffed by Prison Officers (therapeutic parents)
- Supported by dedicated Governor(s)
- Specialist Support staff:
  - Mental Health Nurse – dedicated caseload
  - Clinical Nurse Specialist (mental health)
  - Consultant Clinical Psychologist
  - Consultant Psychiatrist (ad-hoc)
  - Speech & Language Therapist
  - Learning Disabilities Nursing
  - Dedicated Education staff
Willow Unit – Psychologically informed Interventions

- Training staff in therapeutic model: attachment/trauma
- Regular consultation to staff re: formulation & adherence to therapeutic model
- Consultation to risk management process
- Modelling attunement / co-regulation / interactive repair with staff & YP
- Supplementary ‘therapy’
  - CBT based
  - Art Therapy
  - Emotion focussed
  - Trauma focussed
  - Formulated based on attachment/trauma perspective
  - Often with ‘therapeutic parent’ involvement
Willow Unit – tentative outcomes

- Hard work ... And never plain sailing! Learning & refining as we go....mixed picture but promising.....

Mitchell & Ryan (in submission)
- N=41 / 24 months
- Very few transfers out
- 1/3 re-integrated into normal regime
- Measures: Clinical rated, staff rated and YP rated....
- Significant reductions in disruptive/aggressive, overactive/inattentive and self-harming behaviours, and an improvement in self-care and independent living skills at discharge
- Significant reductions in assessment of risk to others and need for both physical (building) and staff security at discharge
- Significant improvement in attendance and compliance with regime
References / Further Reading
* = key texts

References / Further Reading

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