

RELATIONAL-BASED INTERVENTIONS: THE MEDIUM IS THE MESSAGE

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ABSTRACT: In this article we present a framework what we have termed Relational-Based Interventions (RBIs). RBIs highlight the importance of valuing relationships for resilient adaptation and emphasize that how we respond to others, and how they respond to us, defines how we view ourselves as a people. Drawing upon attachment theory we present a rationale for a stronger focus on relationships in group care settings and provide a basic structure to guide such efforts. While delivering RBIs may appear deceptively simple in nature, we advocate for more conscientious and purposeful use of these types of strategies in daily work with youth living in care.

KEY WORDS: attachment theory, staff-youth relationships, resilience.

Efforts to promote resilient development in youth are of particular importance for young people living in care. Within the study of psychology the term resilience has generally come to refer to “a dynamic process encompassing positive adaptation within the context of significant adversity” (Luthar, Cicchetti, & Becker, 2000, p. 543). Therefore, resilience is not a static trait of the individual, but a series of contextual, dynamic, and interactive processes, which draw upon resources within the individual, the family, and the wider social environment. In fact, current research in the field suggests that resilience is not a magical, extraordinary quality in a person, but a common experience that occurs from basic, “ordinary” human adaptational systems (Masten, 2001).

One of the most consistent findings in resilience research is the strong value of supportive relationships in a young person’s life. A young person’s social networks, both formal and informal, are related to favourable outcomes. Interpersonal attachments are important conduits for realizing normal development in all young people, but they appear to have particular protective value for young people who face adversity (Masten & Reed, 2002).

For over a century attachment theory has also told us that connection to others is a fundamental human need and the basis of healthy development.

In the early part of the 20th century Freud's view of attachment, or these 'bonds of mental energy' (Freud, 1989), was that they were so significant that when there was a threat to attachment it would necessarily bring about activation of one of the predefined defined defense mechanisms, which would in turn play a large part in the development of the individual's personality. In the latter part of that century, Bowlby (1979) proposed that attachment is both inherent, as a response to danger, and experiential, in the manner in which attachment is played out, and thus core to our safe relationship to the world.

If a function of attachment behaviours is to ensure safety, the effect of attachment is that it becomes the 'safe base' for an individual's exploration behaviours, a necessary requisite for cognitive, social, emotional, and physical development. Safe early attachment opportunities and the effect they have on exploration and growth are reported to be the most critical from birth through early childhood as this is when the brain is most sensitive to social, emotional, cognitive, and physical experiences, both positive and negative (Perry, 2002). It is the balance between a child's attachment seeking behaviours and a child's exploratory behaviours that were first demonstrated through the now famous 'stranger situation' experiment by Ainsworth and Bowlby (Ainsworth, 1978).

These early experiences in relationships form the internal working models that are the basis of future attachments (Bretherton, 1992) and inform the general conclusions young people make about themselves and others. These conclusions include whether they possess the qualities that attract the care giving and benevolence of attachment figures (i.e., am I worthy of being cared for properly). Other conclusions may include the degree to which others possess the capacity and predisposition to provide nurturance and protection (i.e., can adults be counted on to take care of me and meet my needs). Interactions, or the dance, between children and their caregivers over time create and solidify beliefs about the self and others.

WHAT CAN GO WRONG?

When children do not have stable emotional attachments with primary adult caregivers for whatever reason, there are often severe long-term consequences (Cooper, Shaver, & Collins, 1998; Rosenstein & Horowitz, 1996). These consequences are evident in the potential for slower or arrested development (Neufeld & Mate, 2004) and have implications for overall brain function (Perry, 2002).

The attachment dance can be interrupted for many reasons, such as a lack of parental availability to connect with the child. Some infants are not offered a readily available attachment figure as in the case of infants who were raised in multiple placements or orphanages. Other sources of attachment problems experienced by children in care are those that arise as a result of neglect or abuse.

Neglect can occur from something basic such as the parent not knowing how to meet the child's needs. The parent may have been raised in an environment or family that did not offer examples of active attachment dances for them; they may be young parents who are not prepared, skilled or given role modeling related to attachment, and they may not have the emotional resources to reach out. Neglect can also happen when parents suffer from addictions or abusive relationships which keep them unavailable to meet their children's needs.

These problematic attachment relationships can affect children in numerous ways (Rosenstein & Horowitz, 1996). Children may become insecure and in desperate need of care giving. In this case, the child necessarily spends more time seeking out attachment and less time exploring their environment. The child may develop a pattern where they move from constantly seeking out their primary attachment figure to seeking out attachment indiscriminately. Another pattern children may develop is to become detached from adult caregivers. They may choose to seek out other attachments that provide them with predictable attachment patterns although not necessarily healthy ones (i.e. friends, drugs). Often these young people end up living in group care situations due to their parents' inability to look after them or their externalizing or internalizing behaviours. By the time young people enter care they often have set a pattern of attachment behaviours and beliefs that put them at risk and are difficult to replace.

These young people have been deprived of the critical belief that adults can be counted on to care for them and/or that they are worthy of care. Instead, they often come to foster care or residential life with a core belief that *caregivers cannot be trusted*'. This leads to beliefs that include;

- I can only depend on myself.
- It is dangerous to trust others.
- I am unworthy of being treated well.
- I must be in, or create, crisis to be cared for.
- I will not care for myself.
- People who treat me well want something or want to use me.

What results are *behaviours* that reflect these beliefs, such as pushing others away, not accepting offers of care, and aggression toward caregivers or self-harm.

RELATIONAL EXPERIENCES IN RESIDENTIAL CARE FACILITIES

Upon entering care many young people try to engage caregivers in ways that are consistent with working models from their past experiences of care. These are the relationships that, while they may be harmful, are what the young person is used to and feels is able to deal with best, that is, "misbehaving to invite rejection", or 'rejecting care'. Youth in care are

most often met with an environment that is different from their past. Residential settings typically strive to incorporate some type of 'milieu therapy' that provides safety, structure, support, connection, and validation (Crouch, 1998). For a young person who is experienced in avoiding connection through misbehaving, meeting caregivers who are safe and perseverant will be uncomfortable. The caregiver's stance of safety can seem unbelievable or unnatural for young people with histories of abuse. This discomfort often results in young people attempting to engage their caregivers in ways that reflect their past experiences of care rather than what is being offered them. As they are most comfortable in their past roles of abuse, young people can be masterful in creating new rejection with troublesome behaviours that reflect conclusions that young people have reached about themselves. As caregivers we should keep this perspective in the forefront of our minds in order to be therapeutic and in order not to take the young people's behaviours personally!

All behaviour has meaning, so it is important not to focus on behaviour as either good or bad. Instead, if we simply view it as communication, we have an opportunity to work through old patterns. Behaviours we observe can be effective ways in which to see the child's past and plan our actions to help them see a new future.

CAN ATTACHMENT PATTERNS CHANGE?

Changing a young person's attachment dance through new interpersonal experiences is not impossible, but it is a slow process (Moore, Moretti, & Holland, 1998). When a child experiences adverse events through relationships (e.g., neglect, loss, threat, and injury) there can be neurodevelopment disruptions that will result in compromised functioning throughout life. However, when such children are placed in predictable, nurturing, safe, and enriching placements, over time improvements, such as dramatic increases in IQ scores, improved social skills, and healthier relationships, can occur (Perry, 2002; Tully & Brendtro, 1998).

WE THINK WE WORK RELATIONALLY ... BUT DO WE REALLY?

The struggle between a focus on punishment and control versus a focus on relatedness with clients has been a long-standing issue in the helping professions (Garfat, 2003). While there appears to be a current trend towards adopting more relational-based and less behavioural, control-oriented approaches (Lieberman, 2004), such transitions are difficult to negotiate and require commitment to complete cultural shifts within an agency (e.g., Moore et al., 1998).

In a study by Abraham, Reddy, and Furr (2000), both adolescents and mental health workers perceived informal relationships between the young people and adults at a psychiatric facility as the most helpful component in a residential treatment setting. "Informal relationships provide adolescents a broad range of social support and opportunities to actively seek out

adult assistance, establish and explore healthy relationships with adults, and minimize feelings of loss and separation" (Abraham et al., 2000, p. 63). This is a sentiment that is not uncommon with residential care workers and foster parents (Little, Kohn, & Thompson, 2005). It is not, however, easily reflected in plans of care for young people. Child care workers are often well trained in the areas of behaviour management, communication, limit setting, and role modeling; however, there is no prescriptive model for interaction with young people (Pazaratz, 2003).

Care plans are often replete with interventions for the symptoms of the problem (e.g., reductions in self harm, substance abuse, or aggression) and social skills improvements, although rarely include relational goals. These methods of symptom relief are often more easily written in the form of goals or contracts that measure the reduction of the young person's symptomatology and manner in which the staff is to assist them through the offer of reward for success or consequence for failure. While behavioural techniques may play a role in therapeutic work, when young people do not trust or buy into 'the system', they can be a frustrating exercise. Logic would dictate that if a young person 'invites rejection' or 'rejects invitations' the best laid plans for skill or behaviour training will be met with skilled rejection behaviours.

The rejection behaviours can also be triggered by the type of behaviour improvement techniques that are offered. For example, regardless of how logical or natural the consequences may seem, we need to consider what message our techniques send. Rewards that include 'one to one' time with staff or permission to be included in group activities can send the message that connection with others, as in their past, is conditional. Time out, time away, or loss of 'one to one' time as a consequence, can be perceived as 'you are not worthy of our caring if you don't behave in the way we would like'.

Care plans need to begin with a review of the young person's past attachments to prevent additional injury. Whatever techniques are being offered, it seems central that they are offered through a healthy connection with the young person which means that the first priority is relationship. In the past, therapeutic strategies for 'improving connection' have been problematic. Some strategies to improve attachment or redevelop attachment have arisen such as 'holding therapy' or 'rebirthing techniques'; however, these therapies are often intrusive, shaming, and can reinforce the negative beliefs that young people have about caregivers (Dozier, 2003; Haugaard & Hazan, 2004). In developing techniques for this population it is important not to repeat the offences of the past and instead to offer something different.

When young people with damaged attachment come into care, the first priority is to offer them a new relational experience and, therefore, new beliefs about themselves. We can do this through a new 'attachment dance'. While they cannot re-experience what was lost in infancy and early childhood, they can understand, on cognitive and emotional levels,

new types of relationships that are offered and make different choices based on this information. A healthy 'attachment dance' offers the young person what the original should have. It includes steps to show individuals that they are of value, steps to show they are cared for, and steps to show them that caregivers can be trustworthy. While the dance is new to them, it is unfamiliar and, therefore, not to be trusted; however, if caregivers can show tenacity in their expression of value, consistency, and structure, the young person may learn the steps.

WHAT STOPS US?

So why is it that we do not give a larger portion of attention to the relationship if it is a large proportion of the treatment? There are several answers to this question, the first being that relationships seem intangible to document and measure. Funders of programs are often looking for 'evidence-based treatments' which require prescribed types of program plans, such as manual-driven treatments. As a result, programs often have good tables and charts to demonstrate a reduction in symptomatology such as skills for increased school attendance, reduction of substance use, or an increase in prosocial behaviours that are critical to the child's development. It is important to remember that goals of connection and relatedness are not incompatible with other treatment modalities and should not be unnecessarily forsaken.

Another real-world problem is that institutional resources are often a restraining factor on staff-youth relationships. Governing boards and administrators may be operating under financial and staffing constraints which impact institutions' day-to-day operations. Child care workers who need to make meals, organize activities, communicate with families and other guardians, manage crises, complete paperwork, and so forth, may be doing so under less than ideal staffing situations. It is important to keep in mind that the aforementioned activities are not incompatible with relational work even if all too often we see time with clients as what we get to do after these other, more pressing things, get done. We are teaching kids how to think and feel about themselves in every moment, not just the moments we have after everything else is taken care of.

Reluctance to risk working relationally may also be related to policies and procedures set up by agencies which may promote adherence to standards and inadvertently focus too heavily on the need to control young people in order to meet agency standards (Fewster, 2002). In such cultures, more control-based behavioural interventions will be particularly appealing to staff members, especially in comparison with relational work, which requires taking greater personal risks and is certainly much more complex and demanding than more prescriptive, control-focused intervention strategies (Fewster, 2002; Garfat, 2003).

We also do not talk about this part of treatment because we sometimes believe it will take care of itself. We think it should be intuitive and, therefore,

unnecessary for us to concentrate on. This is a dangerous way of thinking about working with vulnerable youth. Young people enter programs with working models of past attachment that assume adults cannot be trusted and will provoke adults to fit into their beliefs about relationship (Pazaratz, 2003). There is also evidence that child care workers' perceptions of youth, such as whether they are easy to work with or are seen as having a bright future, will impact relationship (Moses, 2002) and the tenacity with which they offer care. Every staff in every residential setting has some sort of relationship with the young people they work with, so we need to pay attention to that relationship. We may think that our relationships with some young people are not significant, and they may tell us so, but young people, regardless of their life experience, continue to need caregivers. Even if we don't want to acknowledge it, there is meaning in every interaction. Limiting our interactions, such as not showing up for special events of young people or forgetting a commitment, all send strong messages to our young people about their value in this world.

Finally, at times caregivers show concern that they will only be with the young person a short period of time and feel it is not fair to connect with the youth as, when they leave their care, the separation will be another rejection. A corollary to this is that staff members believe that the youth have other attachments that are more important. Relationships do not need to be long-term. Short-term attachments can be very meaningful, for example, a caring teacher or a summer camp counsellor. A natural ending to a relationship will bring sadness and feelings of loss, but this is distinctly different from rejection. Young people need many close relationships throughout their lives.

RELATIONSHIPS ARE THE MESSAGE

Common-factors research suggests that therapeutic relationship factors, such as warmth, acceptance, empathic understanding, and client-therapist agreement on goals, account for approximately 30% of treatment outcomes (Asay & Lambert, 1999). Furthermore, the importance of relationship has been well-established as an essential component to the treatment process in residential settings (O'Malley, 2004). However, it would be wrong to view relationships as merely conduits for other forms of intervention.

The therapeutic milieu is a primary agent for change with youth. "The twenty-four hour care provides opportunities for critical, repeated interactions between staff and clients. It is these interactions which provide the young people the opportunities to feel understood, cared about, cared for and safe in this environment" (Berlin, 2001, p. 2). In fact, relationships are not simply a means to influence behaviour; rather, they are a vital message to the individual about their inherent worth. Long-lasting change requires individuals to see themselves differently--to have a stronger sense of value and deservedness. *We can not train insecurely attached young people to be prosocial individuals who care about themselves, others,*

and society. If young people continue to view themselves as unlovable, undeserving, and unworthy, any behavioural changes they make are not likely to be long-lasting or transferable. New, more positive, self-views support the attainment of skills, the development of increased competence, and the desire to be successful.

RELATIONAL-BASED INTERVENTIONS

Relational-Based Interventions (RBIs) is a term that we have coined to reflect the goal of ensuring that all of our treatment interventions are consistent with, and ultimately enhance, the aim to have young people view themselves as valuable, connected, and safe. RBIs emphasize that how we respond to others, and how they respond to us, defines how we view ourselves as a people. Parents' responses to their children are how children begin to discover themselves (Tolmacz, 2003). If we talk to, look at, or laugh with someone as if they have a good sense of humour, they will believe they have a good sense of humour. If we talk to someone as if they are not important to us, they will view themselves as unimportant.

RBIs are in and of themselves treatment. This means that the first and most important task of caregivers is to develop this valuing and respectful relationship that increases the safety and trust the young person has with us and gives them a new message about themselves. Effective treatment necessitates this door be opened before anything more therapeutic can happen. We cannot assume that young people should be expected to follow our lead or follow our rules of behaviour automatically, as though they can see or understand upon our meeting that there is value in our relationship (Neufeld & Mate, 2004). As described above, most of the young people in our treatment programs do not see the safety or value in a relationship with us until they have been taught by our behaviour that there is (McGee & Menolascino, 1987).

The term RBIs refers to the goal of providing all treatment within a relational approach, not an exact process or specific technique. They are the frame with and within which we deliver treatment. RBIs are any treatment interventions which are primarily characterized by three dimensions which;

- a. show the young person they are of value,
- b. demonstrate and teach appropriate socio-emotional responses,
- c. provide structure and security.

In addition to drawing upon principles of attachment, these three interrelated aims reflect the goal of resilience in young people by strengthening intrapersonal factors, such as feelings of self-worth, as well as building interpersonal skills and drawing upon available supports from the young person's environment. The three components of RBIs also combine the complimentary goals of relatedness and control, which are all too often viewed as incompatible (Bath, 1995; Mann, 2003).

Therapeutic interventions are often simple, but this does not necessarily mean that they are easy to implement and maintain in the face of daily struggles. Working relationally may appear deceptively straightforward, but it does require purposeful planning, implementation, and on-going self-reflective practice in order to be effective. Only through vigilant self-examination, good communication, and collaboration can a staff group keep from falling into the trap of helping the young person recreate their past. These interventions are by far more taxing on a caregiver than most, and self-reflective practice is vital. While relational work cannot be prescribed, there are some basic goals which we believe are important to keep in mind. Table 1 identifies the goals of each of the three key components of RBIs, provides examples, and also highlights some self-reflective questions for professionals working with young people in care.

ANTICIPATING CHALLENGES

In offering RBIs it is important to remember that many youth in care do not know how to respond to valuing messages. When a young person who believes they lack value and believes that the world is a frightening place encounters caregivers who extend unconditional positive regard, they may find this to be uncomfortable and/or unbelievable. These new experiences can be very stressful for young people and may lead to feelings of confusion, anxiety, sadness, and anger. Such intense emotional experiences may lead to avoidance of caregivers and/or attempts to pull caregivers into old patterns of interaction, such as misbehaving to invite rejection.

Many acting out behaviours are designed to gain rejection, and all too often they are successful. Their verbal or physical aggression results in separation or confinement and their unkempt or offensive appearance results in social rejection. Such examples highlight the importance of self-reflective practice which works to create change rather than reinforce old patterns. Such reactions reinforce the importance of providing tenacious care giving that is characterized by patience, consistency, and recognition of the unpredictable path of progress.

CONCLUSION

Our clinical experience tells us that adult relationships in the lives of youth in care are of vital importance to normal development and that they are a very valuable, and necessary, modality for treatment interventions. Few people working in the field of child and youth care would argue about the importance of interpersonal connections. However, despite this apparent consensus, there appears to be insufficient attention to consistent and systematic implementation of relationship-based practices in group care situations.

In their review of decades of resilience research, Luthar and Zelazo (2003) concluded that to a large degree, "*resilient adaptation rests on good relationships*" (p. 544). The components of Relational-Based Interventions

Table 1***The Three Components of RBI***

Goals	Examples	Self-reflective questions
A. Show the young person they are of value		
1. For young people to see their inherent worth and their unlimited potential through the eyes of trusted adults. 2. To use daily interactions with young people as opportunities to communicate the most important message: "You are worth being cared for."	<ul style="list-style-type: none"> • Stop, sit, listen-spend time and enjoy who they are. • Validate their feelings. • Identify, explore, and highlight their strengths • Create and document memories. • Have rituals to celebrate special occasions. • Teach the young person new skills and give them opportunities to succeed. 	<ul style="list-style-type: none"> • Do I make eye contact with the young person and greet them every time we are in the same room? • Do I validate the young person's feelings even when their behaviour may frustrate or annoy me? • Do I truly enjoy the time I spend with this person?
B Demonstrate and teach appropriate social-emotional responses		
1. To change old patterns of interaction by experiencing new responses from trusted adults 2. To enhance relationships by learning and practicing new interpersonal skills.	<ul style="list-style-type: none"> • Think about acting out behaviours in terms of information. • Regularly discuss the impact of thoughts and feelings on behaviour. • Be authentic-express your emotional responses to situations in safe ways. • Provide specific instruction around social interactions with peers and adults. 	<ul style="list-style-type: none"> • Do my attempts to deal with behavioural issues reject the young person? • Do I model appropriate ways to share both positive and negative feelings? • Do I make time to reflect on what the young person's behaviour says about how they see themselves?
C Provide safety and structure		
1. To become a secure base from which the young person can explore and take new risks. 2. To help the young person generalize feelings of security beyond the treatment relationship by building networks of support.	<ul style="list-style-type: none"> • Be consistent, repetitive and predictable. • Have appropriately high expectations. • Support the young person in connecting with other adults and prosocial peers, as well as making new connections in the community (e.g., a job, organized activities, sports teams or a mentor.) 	<ul style="list-style-type: none"> • Do I regularly check in with the young person to ensure they feel safe? • Does this young person have several sources of validation and support? • Do I maintain appropriately high expectations and standards even when this displeases the young person?

we have discussed in this article simply highlight the importance of what has been established in the existing resilience research by drawing upon attachment theory to identify a purposeful framework for relational work with young people living in care.

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