

Guest Editorial

John Davy & Julia Hutchinson

WELCOME to this special edition of *Counselling Psychology Review* about work with children and their families. Although there are already a number of counselling psychologists who undertake such practice in the UK and have written about this (e.g. Hurn, 2006), it is fair to say that work with children, adolescents and families has a lower profile within our Division than work with adults. We hope that this edition will give readers a taste of counselling psychology's application to children and families, and some ideas about the pleasures and pitfalls in this field.

The majority of applied psychologists who work with children in the UK are either clinical psychologists, mainly in the NHS, or educational psychologists, mainly in schools and education departments. A much smaller number work in other settings such as youth offending services, voluntary organisations, social care settings and private practice. One of the complexities of work with children and young families can be the large number of different services and settings involved when there are serious problems. Historically, producer-oriented rigidities about locating one type of psychology in one setting can lead to fragmented support for children who have serious illnesses, major disabilities, or who have suffered abuse and neglect and may need care outside their family of origin. Government policy asks public services to work together to safeguard children's best interests (HM Government, 2006), and urges professionals to avoid 'silo mentalities' by showing flexibility and imagination in new ways of working together (Lavender & Hope, 2007) across agencies and disciplines. However, there is a long way to go. Children experiencing or at risk of significant psychological distress and possible longer term harm may fall between

the gaps of medically oriented 'mental health' provision and traditionally more behaviourally-oriented educational and social care services.

Potentially, counselling psychology has a lot to offer. Unlike educational and clinical psychologists, our training and outlook is not so strongly linked with a particular institutional setting like the NHS or schools. Our discipline's relative youth and diversity means we could be well suited to serve children flexibly across different contexts, and to help build bridges between these at both practical and theoretical levels.

Counselling psychology emphasises a relational and holistic perspective, trying to understand and support individuals with reference to the multiple contexts of their lives, interpersonal, social/political, cultural and physical/ecological. Further, counselling psychology tends to emphasise process, and the importance of growth, change and development. This is important and helpful in working with children who are constantly 'becoming', shaped by parenting and family experience, school and peer relations, and, of course, broader images and expectations within society about the nature, worth and purpose of children and childhood.

The evidence base for different types of psychological therapy and counselling is more limited with children than adults. Some reasons for this may include; ethical and practical problems with research design and recruitment where children are involved; under-funding of services for children compared with adults; difficulties selecting relevant and practical outcome measures which can discriminate between therapy effects versus multiple other concurrent influences on children's lives, and which are sensitive to long-term develop-

mental outcomes rather than short-term symptomatic change only; limited training for researchers about specific methods and models for engaging and understanding children's minds and communication, and so on. Historically too, originators of 'talking therapies' such as Freud, Rogers and Beck, developed and tested their ideas primarily through work with adults even when their theoretical models postulated childhood origins for adult difficulties. One consequence is that therapies used with children are often slightly modified versions of adult-oriented therapies rather than approaches designed for and researched in relation to children and their families.

We suggest that counselling psychology has a lot to offer in developing and using evidence-bases for therapeutic work with children, particularly since we are not 'just' counsellors. In addition to our skills and understanding across different psychotherapies, we are also professional psychologists who can bring to bear knowledge and understanding of family processes, the social psychology of childhood and parenting, child and life-span development, research on attachment, resilience and coping styles, multiple memory systems and learning theory, attribution and positioning theory, motivational systems including peer influence, etc. All of these should place us in strong positions to adapt, evaluate and innovate aspects of psychological therapies so that counselling work with children can be informed by well grounded evidence from psychological research.

Sounds good. So why aren't there more of us, and why doesn't child-focused work have a higher profile within counselling psychology?

One issue is simply that the child sector is small compared with adult work; there are more adults than children in the UK, and more adult oriented settings. Further, services for adults tend to be better financially resourced per head of population than those for children (or others who don't have the vote or seem less economically produc-

tive). Lord Layard's recent initiative to expand access to psychological therapies (IAPT) is an adult-oriented project, partially justified as an attempt to save the Treasury money by returning economically inactive adults to work. Improving psychological services for children doesn't seem to offer similar short-term financial incentives for central Government investment. We will probably soon see some projects piloting versions of IAPT for children, and indeed Layard and Dunn (2009) have recommended just this in the recent Good Childhood Inquiry, but these are unlikely to attract the same level of investment, especially in view of the poor state of Government finances. Although early effective intervention in troubled children's lives could have the potential to save the taxpayer money in the long term, 10 or 20 years on, politicians tend to plan and budget in relation to four or five year electoral cycles. Investing money in youth offending services has more potential to win votes if anti-social behaviour can actually be reduced, than investment in services for babies and infants with poor attachment experiences and multiple adverse experience (Gerhardt, 2007), who may be significantly at risk of presenting with pervasive and expensive problems in adolescence and adulthood.

Taken as a whole, this means that there are fewer posts in child work, and consequently fewer training placements, fewer counselling psychologists ready and able to fly the flag for such work within the Division, offer specialist supervision, and so on. Additionally, unlike clinical and educational psychology, counselling psychology training does not require supervised clinical practice with children and adolescents in order to qualify. Our discipline's diversity and flexibility can be a disadvantage at times. Counselling psychologists can complete an entire doctoral training with very little practical experience of child work if they choose, although academic input about child and family work is required. It seems that courses vary in how substantial this is, and how much

trainees are actively encouraged and supported to seek child placements. This might sometimes reflect the interests and skills of core course staff. This is not just a skills issue; counselling psychologists who have not undertaken a clinical placement with children will not build up the same professional networks as those who do, and may also struggle to convince interviewers for funded posts of their suitability compared with rival candidates who have successful child placement experience.

In common with counselling psychologists working in other settings, those of us who work with children may have less institutional power and an uphill struggle to gain credibility in some settings compared with other applied psychologists, precisely because we are newer, fewer, and less well understood by consultant psychiatrists, paediatric surgeons, social workers, probation officers, head teachers and so on. There is no quick fix for this. We need to be seen to be effective in our own right, to make it clear who we are, and to show what is different and distinctive about our contribution, while respecting the roles and expertise of others and demonstrating that we can work well as team players with those from other backgrounds. Given tight financial constraints in modern practice, we need to show clearly how the psychology side of our counselling psychology identity allows us to bring added value over and above that which someone else with sound training in one particular model of counselling/therapy can bring.

Why work in child counselling psychology? As already highlighted, it offers excellent scope to utilise both counselling and psychological knowledge, drawing on a wide range of theoretical domains. It is hard to work effectively with children without taking their multiple contexts properly into account, so it is both a requirement and privilege of child counselling psychology that good practice must be relational and genuinely holistic. Given the limitations in the current evidence base, and the diverse settings and stakeholders that may matter, it

is necessary to have a capacity to work and communicate flexibly, to innovate, and to keep in mind several different agendas and interests simultaneously without being deflected from the child's best interests. The differences and limitations in children's language and cognitive development can be challenging for adults working with them, as can the need to balance taking psychological distress seriously with the importance of play and playfulness in child development. Child-focused practice is for psychologists who enjoy such challenge and diversity.

Working with children and adolescents also offers real opportunities to make a meaningful long term difference to developmental trajectories. Work with families and new born babies can be very challenging, but if done well has the potential to mitigate many future problems, taking the idea of 'early intervention' seriously. Of course, working with adults about historic childhood abuse can be very satisfying and valuable, but working with families and children to address abuse, or the risk of this, in the present has preventive value and is consistent with our discipline's aim to promote well-being rather than simply treat problems.

A shadow side of this is the heightened potential for psychologists working with children to become caught up in rescuer fantasies, for example by attempting to be a 'better parent' in some way than the child's actual parents. This carries a risk of undermining the child's relationships with significant others already in his/her family and natural networks, as well as a danger of promoting a degree of dependency that the psychologist may not be able to satisfy in the longer run, rather than promoting the capacities of the child to support him/herself and make good use of help from those around them day to day. Similarly, counselling psychologists working with children need to be prepared to tolerate the considerable levels of personal distress and anxiety that are often evoked by knowing that a child remains very distressed, or at some continuing risk. Hearing an adult

talking about past abusive experiences presents a different emotional challenge for a psychologist compared to watching and hearing abusive or neglectful interactions actually taking place in the here and now. Psychologists can be drawn into feelings of very painful responsibility for distressed children without being able to resolve the situation. This can be especially acute when working with suicidal adolescents, and with babies who are frightened or depressed.

Related to this, counselling psychologists need to be sensitive to, and capable of responding appropriately, to children's limited power and autonomy compared to adults. On the one hand, there may be a role for advocacy, helping children to make their views and voice heard more clearly. But on the other hand, counselling psychologists working with children need to be careful not to fall into unhelpfully oppositional relationships with other adults who exercise control over whether a child can or can't come to a therapy session, what school they can go to, etc. Children often suffer when adults around them start to argue and fight. Counselling psychologists in private practice working with children need to be particularly careful of the dilemmas inherent in working with vulnerable minors when it is not actually the child client who is paying for the work. It may be hard for the child to decline therapy that others think they should have, or conversely for a child to hold onto a therapy they want if they are not changing their behaviour in ways that others consider important.

But enough of the background, and on to the articles themselves! We present a selection which covers a range of experience and expertise, from two trainee perspectives by Sinitsky and Riha, to Hammersley's article on independent expert witness practice and Woodhouse's article on managing a child

and adolescent mental health service. We've also tried to address work with children of different ages, from Puckering, McIntosh, Hickey and Longford's article on mellow parenting work with new babies, through to Gaffney's piece on football metaphors in psychotherapeutic work with adolescents. Some of the papers concentrate on individual therapy work, such as Quinn's article on existential-phenomenological practice with children, while other papers, such as Hutchinson and Pretelt's article using positive emotions in therapy with primary age children, concern group work. Taken together, the articles draw on ideas from psychoanalytic theory, cognitive-behavioural therapy, solution-focused work, positive psychology, attachment, systemic/narrative practice and existential-phenomenological theory, amongst others. Reflecting the diversity of our profession, our authors work in private practice, in NHS child and adolescent mental health services, in schools and in voluntary organisations.

Obviously, it's not possible to provide comprehensive coverage in an edition like this. We're aware, for instance, that there are no papers which focus on paediatric settings/physical illness issues, or on psychotherapeutic work with children who have significant learning disabilities. But we're sure that the articles will stimulate both playful and serious thought and discussion, and who knows, perhaps tempt a few more colleagues into child-focused practice. For those of you who stay working with adults, please bear in mind that many adult clients are or will become parents, grandparents, uncles, aunts, etc., and keeping children in mind can be an important part of counselling psychology outside child settings too.

Enjoy!

Correspondence

Dr John Davy is Principal Counselling Psychologist in Cambridgeshire and Peterborough NHS Foundation Trust and a Partner with the Health Professions Council.
Brookside Family Consultation Clinic,
Douglas House,
18 Trumpington Road,
Cambridge CB2 8AH.
E-mail: john.davy@cpft.nhs.uk.

Julia Hutchinson is a Counselling Psychologist at West London Action for Children.
West London Action for Children,
15 Gertrude Street,
London SW10 OJN.
E-mail: julia.hutchinson2@btinternet.com

References

- Gerhardt, S. (2007). Making a person: The lasting impact of babyhood. *Counselling Psychology Review*, 22(3), 37–44.
- Hurn, R. (2006). Snakes and solutions: An example of using a traditional board game to exemplify the techniques of solution-focused therapy. *Counselling Psychology Review*, 21(2), 12–18.
- HM Government (2006). *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*. London: TSO. Retrieved from:
www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/
- Lavender, T. & Hope, R. (2007). *New ways of working for applied psychologists in health and social care – the end of the beginning*. Leicester: The British Psychological Society. Retrieved from:
www.bps.org.uk/the-society/organisation-and-governance/professional-practice-board/ppb-activities/new_ways_of_working_for_applied_psychologists.cfm
- Layard, R. & Dunn, J. (2009). *A good childhood: searching for values in a competitive age*. London: Penguin. Also available at:
www.childrensociety.org.uk/all_about_us/how_we_do_it/the_good_childhood_inquiry/report_summaries/13959.html

The Teenage Psychotherapy First XI: On learning from the beautiful game

Paul Gaffney

This paper attempts to give an overview of what counselling psychologists can offer in the arena of child and family work. This paper is written from the perspective of working with a broad range of young people including what are referred to as 'difficult' or 'hard to reach' adolescents, sometimes in crisis.

In order to highlight the importance of developing as a therapist, rather than slavishly endorsing one approach over another, the paper focuses on clinical pointers that I have found useful in my work, described here as 'The Teenage Psychotherapy First XI'. Within these pointers, I outline the need to be flexible in every situation, reflect upon what has worked well in practice and continuously learn about the therapeutic process and my role in it. Clearly, it is a work in progress.

Introduction or why bother?

FOOTBALL is a universal concept (although in some places it is called soccer!), played in over 200 countries, with 270,000,000 players and referees, or four per cent of the world's population (FIFA, 2009). In my therapy work with adolescents, football is often a 'safe' area of conversation/discussion for adolescents, and while it will not suit everyone it seems to be one of the easier ways for a therapist usually some 25 years older than the adolescent client. What might be football for one psychologist could be music, literature, or movies for another psychologist. The key is an area of genuine common interest.

Many sporting analogies/metaphors have made the transition into common parlance, and both football and therapy analogies can apply. The 11 pointers that follow are based on a humanistic and positive psychology foundation, informed by cognitive-behavioural, solution-focused and systemic theory. In my experience, the pointers can help frame the therapeutic relationship, provide a basis for mutual understanding and provide links back to evidence-based practice.

In this paper I have tried to shed some light on what actually happens in the therapy work I undertake with adolescents. If it appears idiosyncratic, quirky or even frivo-

lous, I think this reflects not just on the author but on the massive challenge facing those of us who try to bring psychological therapies to adolescents. This challenge is influenced by recent trends in the adolescent population who present to us, who seem to have more complex needs, with more chronic and extreme difficulties (Selekman, 2005). This is not helped by the risk laden context of many adolescents referred for psychological help. This context includes family disconnection and breakdown, social disadvantage and injustice and the more recent economic uncertainty, both nationally and globally.

I would like to share the 11 pointers which I have found helpful in my practice, currently within a multi-disciplinary community Child and Adolescent Mental Health Service (CAMHS), in the hope others might find them worth considering. Names and details have been altered to protect anonymity.

1: 'Pick your strongest formation'

Working with adolescents, especially hard to reach adolescents can seem very challenging when assessment identifies distress and difficulty at many levels. Many elements which contribute to their distress, including family and background, where they live and the prevailing culture, expectations regarding

education and potential risk of getting involved in crime or being a victim, are outside of the influence of the therapist. This can feel understandably overwhelming. At these times, highlighting and encouraging resources, protective factors, strengths and positive values and what matters in life (Seligman, 2002), both for the adolescent and the family/carers, is invaluable for informing the therapeutic plan and establishing a therapeutic relationship.

In my experience, over 50 per cent of referrals to our CAMHS service concerns queries around possible Attention Deficit/Hyperactivity Disorder. However, in the context of, for example, time spent with friends, some features of this condition can be pro-social and positive, including high energy levels, natural curiosity and willingness to try new things (Hanos-Webb, 2005). However, in other more controlled contexts, such as school, these features can be problematic. What seems to help is accommodation of the young person's traits within and between settings while helping them learn to better manage situations. I have also found it useful to focus both in my shared formulation with the adolescent and those who care for them, on broader interpretations of ability, especially Gardner's Multiple Intelligences Framework (1999). In this way classifying intelligence, hyperactive or very busy adolescent behaviour could be categorised as *bodily-kinaesthetic*, one of 10 possible areas. This helps reinforce the point that psychological intervention for conditions such as AD/HD is not just about nullifying problems but strengthening current ability, especially if in an appropriate context, which can potentially enrich the life of the adolescent and those around them.

16-year-old Colm tended to find traditional therapy quite challenging and stated that simply sitting and talking was very frustrating. However, when given a choice of activities, some assessment items and/or talking a little, he seem to enjoy this mix as well as the element of some choice. This helped build rapport in the early stages of therapy work.

2: 'Both of us have to want to be on the team'

The quality of the therapeutic relationship between the therapist and the adolescent remains a powerful and reliable predictor of outcome and success/termination and failure (Yalom, 2002). What seems to help is to acknowledge the adolescent's right to choose to participate or withdraw and offer choice, both in terms of issues to be tackled and the menu of approaches we can offer (Hoyt, 2006).

It is also important that we do not lose the uniqueness of each person and each situation by not allowing specific therapeutic models to become a tyranny but instead recall Yalom's instruction that:

'The therapist must strive to create a new therapy for each patient.' (Yalom, 2002, p.34)

In a similar vein, I have found it useful to also reflect on the fact that therapeutic relationships need to be carefully constructed, worked on and toiled over (Digney & Gaffney, 2006). This is especially the case when the psychologist's relationship with the adolescent is not solely a once weekly visit, for example, within a residential care setting.

I learned much from a 17-year-old client whom I worked with in a high support residential centre where I was both the centre psychologist and centre soccer team player/manager. An interesting dynamic developed where the scheduled therapy sessions were mainly conversations about his improving ability and ambition and team tactics, but also the beginning of a process acknowledging a number of previous abusive care experiences, and the link between these and his own aggressive and disruptive behaviour. I'm not sure that such work would have happened without our shared experience as colleagues on the football team, and his taking on of responsibility; he was determined not to get sent off even if he believed a referee's decision to be unjust, as the team would suffer otherwise. His asking to take his team jersey at the end of his placement seemed an acknowledgement that the experience had been positive and that he wanted to carry part of this with him.

3: 'If you don't have a goal you can't score'

Goals or wants need to be clearly agreed and measured, and when necessary adjusted and changed. If goals are not useful or the adolescent has difficulty generating these, I have found values, as outlined in *Acceptance and Commitment Therapy* (Hayes, Stroschal & Wilson, 2003) very helpful.

14-year-old Tom was initially very resistant about speaking about impulse control problems that had got him into trouble at school and with the police. Speaking about goals in therapy seemed to agitate him further and he added that the difficulty was not his, but connected to the rigidity and inflexibility of the rules at school and in the community. Once I asked about his values, he began to speak about unwritten and unquestioned ideas in his life, principally connected to looking out for one's family and being loyal to one's friends. Undoubtedly, in some situations these values had been relied upon to justify some behaviours, for example, not co-operating with authorities, but may also have enhanced social status (as well as a coping strategy) in the disadvantaged community where Tom lived. When we spoke about these ideas, Tom was much more engaged and acknowledged that this value system strongly influenced many of his actions and attitudes. This in turn helped Tom acknowledge that his behaviour did not happen randomly and could be changed by looking at underlying ideas and notions that mattered to him, leading to positive behavioural change without infringing on his personal values.

Perhaps in a parallel process, advocacy tends to be critical in these cases and we need to skilfully and diplomatically exert influence in the interests of the young person, highlighting the importance of social relationships and community in influencing psychological well-being (Gilbert, 2009).

4: 'Assemble a squad and use the bench'

In many cases of hard to reach adolescents, there are many people involved in the system (family, friends, professionals from school,

health, justice, voluntary organisations, etc.), who can be potentially positive or negative to the psychological work. These people have opinions on each case and it is important to acknowledge these and try to agree a common agenda for therapeutic work. It is important to use all these resources and harness goodwill (or 'use the bench'), to help ensure a better outcome and greater support for the young person and their family.

Often in working with adolescents, especially those with externalising behavioural problems, the young person is already cut-off from much of their familial and social network as a consequence of violent/threatening behaviour and/or previous failed intervention attempts. In such instances, I have found it important to at least open the network up to some communication again, and if necessary, use close friends to help do this (Selekman, 2005). I explain that in order to help turn a situation around (usually the adolescent and their carers say this will not work anyway!), I will need all their help now.

15-year-old Mark was referred to CAMHS for a variety of behavioural problems, which were becoming increasingly more serious and threatening, involving running away, refusing to go to school and engaging in violent confrontation with his father. Mark made constant promises to me about how he would change his behaviour (curiously, without wanting to discuss his behaviour), but would then act even more defiantly at home. To an outside observer (and to Mark's parents) the weekly therapy sessions seemed to make his behaviour worse. By calling in a number of community supports including a youth advocate for Mark and a family support worker for the family, the agenda became broader and the consequences of what Mark was doing were given due attention as well as identifying eventually that was working well. The individual work also began to include family members and help reinforce two key points that changed the complexion of the case: Mark wanted to stay at home and his family

did want him to stay. What was required was a new way of living together, that individual work alone could not have achieved.

5: 'It's a game of two halves'

In my experience, the most enduring and helpful therapeutic relationships with adolescents have both periods of harmonious and constructive working together alongside periods of less cohesion and differing opinions. This seems more like real life and builds on some adolescents' ability to provide immediate and clear feedback on therapist input which actively promotes problem-solving in the relationship. It also serves to more accurately reflect other relationships and may also serve as a model for how to negotiate other relationships still. I have also found it important to help the adolescent realise that in relationships some level of conflict and need for negotiation is indeed inevitable. I have also found it helpful to recall Rollo May's point that encounter and conflict is useful in and of itself, instead of interpreting encounter (maybe at times, distorting encounter) as transference (May, 1983). For children who often externalise distress and use blaming others as a default position for their unacceptable behaviour, allowing them the opportunity to build a trusting therapeutic relationship while having to experience periods of cohesion and harmony alongside distress and turbulence is a critical opportunity.

14-year-old Mary was referred following episodes of self-harm and what appeared to be restricted patterns of eating. Much of our initial therapeutic work was around building rapport but I was struck how she attempted to mirror my thoughts and feelings and respond accordingly. When I made this observation she became angry and said I must not want to spend time working with her especially as she was trying so hard to make it work. However, following further exploration it emerged that Mary was scared that any disagreement would mean that I would reject her and she would be 'no good' at therapy. Following experiments on bringing conflict into our work and reflecting

on how we did not always see things the same, Mary became much more comfortable in the relationship and seemed to put less pressure on herself. As a result, her thoughts and feelings about expectations and obligations in other areas of her life and in other relationships came more to the fore.

This also relates to changes and developments intra- and inter-personally for the adolescent, in that individual change seems more effective if changes in the wider system occur also (i.e. family, peers, school, training).

6: 'Pass and Move!'

Speed and intensity, as in the game of football, are both critical and some of the cases I see involve an element of crisis. This usually works positively in that the young person is ready to consider assistance, when motivation is highest or when faced with a difficult choice, for example, consent to psychological help or be sent to detention. This also applies to the therapist constantly referring back to formulation, re-formulating when necessary and changing tack to suit the situation. At a very basic level, especially if beginning to feel totally lost or out of touch with a case I have also found the following advice beneficial...

'If they are into the facts, go for the feelings; if they are into the feelings, go for the facts.'
(Hoyt, 2006, p.119)

In terms of intensity, both as early an appointment as possible along with six to eight (where possible, successive) weekly appointments facilitate briefer solution-focused work and/or rapid completion of initial assessment with agreement on a provisional formulation and agenda. Such an approach seems to help foster problem-solving and build resilience, especially with the solution-focused and cognitive behavioural axis which usually works best for me. It is claimed that the greatest amount of therapeutic change occurs in the first six-eight sessions (Smith et al., 1980, quoted in Fraser & Solovey, 2007).

13-year-old Mark who was referred for recurrent self-harm following an episode of bullying, was having difficulty getting to sleep each night and asked for assistance with this at the first appointment. Following the identification of 20 possible solutions (Davies, 2009), Mark agreed to try them all that night. Within two nights he was sleeping through the night. This in turn meant that the issues worrying him while he could not sleep, for example, 'What is wrong with me?' were not such a consideration any more.

The key point in Mark's case was that he had tried most of the 20 ideas suggested before in isolation but not at the same time, so this was an intensive thing to try, reviewed seven days later at the next session. I also advised him that, as this was my strange idea, if it did not work I would take responsibility and suggest something else. Thankfully, following this initial success Mark engaged well and went on to address the distressing issues that had brought him for intervention.

7: 'Take each game as it comes'

While themes may emerge in adolescent therapy work, for example, achieving balance between familial and peer relationships, no two cases are ever alike and the task for the therapist is to create a 'new' therapy for each case. Different models and applications of therapy are required for different situations, requiring variations in time-frame, therapeutic approach/approaches and individual/systemic work.

15-year-old David initially presented with very challenging and difficult behaviours and was resistant to look at the impact of his actions. However, once his parents were invited into a session to help elicit their opinions and thoughts, he found this a much better way to work and the immediacy created by this really helped. Issues were more readily and easily addressed.

Taking each game as it comes works best for me when it also involves a menu of input that the individual therapist or service can provide (for example, models of therapy, group work, and/or befriending). Choice

and responsibility appear to be good qualities to encourage also. Such a menu, especially when some elements are successful in certain cases, can also allow for the therapist to build up a set of 'templates for success' based on what seems to have worked in some cases with the need to create a new therapy approach for each adolescent.

8: 'Get on the scoreboard early'

In my experience, the earlier the therapeutic work begins, the more chance of a successful outcome and avoidance of potential adverse consequences associated with no intervention.

Additionally, in some cases, serious problems have to be addressed or referred on for specialist attention before psychological intervention is appropriate or useful (especially in my experience in the case of child protection issues, school/attendance problems, the medical management of eating disorders and addressing imminent self-harm).

In my experience, it seems best to first try to help *solve* these issues rather than *explain* them, although this can sometimes be the wish of referrers and families when they initially attend. What is central here is arriving at a shared provisional formulation on which to base interventions, and reformulate or alter intervention as work progresses. What works for me is a concurrent development of formulation influencing ongoing intervention, as opposed to two separate phases of work.

What I have also found works especially well here is discussing with the adolescent and their carers and strategically outlining (based on psychotherapy research) the four major estimated factors in psychotherapy success: extra-therapeutic factors, relationship factors, hope and expectancy factors and models and techniques (Hubble et al., 1999).

Extra-therapeutic factors are related to what the adolescent brings to therapy, including their resources and ability, their resilience, readiness for change and motiva-

tion (Hubble et al., 1999). These extra-therapeutic factors account for 40 per cent of positive treatment outcomes, highlighting the need to bring as much of the adolescent's experiences and expertise into the therapy arena (Selekman, 2005). Relationship factors relate to the development of a good therapeutic understanding between client and therapist, involving listening/empathy skills, structuring skills and communication of positive regard by the therapist (Lambert & Barley, 2002).

Hope and expectancy factors are estimated to account for 15 per cent of successful outcome and relate to the client's belief that the therapist and therapeutic experience will help them. Finally, 15 per cent of successful outcomes are thought to be accounted for by the models and techniques employed by the therapist.

9: 'Fancy taking a penalty'

I have been surprised how attempting to facilitate the adolescent to make decisions and come to terms with personal choice and responsibility can positively impact on the therapeutic work. With adolescents, I find that understanding and insight are rarely enough (Hoyt, 2006) and as such behavioural experiments, or seeing the consequences clearly for and by themselves, are important in my work.

Sometimes, there can be a perceived or real pressure to 'fix' everything right away for the client and not *with* the client. In such instances, the following applies:

'The harder I listen, the smarter I get.'
(Hoyt, 2006, p.119)

Such shared responsibility can help the adolescent repair family, social and other professional relationships and help answer the eternal sceptical question 'Has he/she really changed?', or at the very least, attained agreed therapeutic goals.

10: 'Watch the offside trap'

I have found it important to attend to transference, tensions and associated strains within the therapeutic relationship,

involving possibly the adolescent, but also possibly, other people in their environment/situation and my colleagues. I find it useful to regularly ponder often with the adolescent a Dialectical Behaviour Therapy idea that the therapist will have to be prepared to not always have full understanding of each situation (Linehan, 1993)

My use and appreciation of supervision and peer support has proved to be invaluable in my work with adolescents. As the process of therapy (like football) can be understood in terms of expending energy in the service of an agreed goal, knowing when you need to step backwards or switch to a safer topic, take a breather or connect with an alternative energy is vital. I find it useful to recall how privileged I am to be paid to work with children (as I may well have continued as a volunteer in a counselling service had I not got into training) and how the opportunity to potentially help and assist a young person is much more important than the therapist being right or validated all the time. When I regularly get stuck with a case, I find it useful to ponder the following possibilities:

1. We are focusing on the wrong goal, or a non-attainable one.
 2. A miss-alliance has arisen; the client is not ready and/or I am trying too hard.
 3. There is a missed diagnosis (for example, depression, drug use).
- (Hoyt, 2006)

11: 'You can't win them all'

You cannot succeed all the time in every case, and in some cases, *no therapist would succeed*, usually related to factors outside the control of the adolescent and the therapist, including timing and overwhelming environmental pressures. Additionally, if you work with a vulnerable (e.g. self-harming) population, an adverse outcome can potentially occur at any stage (including client suicide or client homicide), no matter how skilled, able or motivated the therapist may be.

Despite this, not attaining agreed therapy goals can be a useful learning step for both

client and therapist. When a young person disengages without achieving their desired outcome/goals, I reflect on the case in supervision and consider; was it something about the process that made it so difficult for the young person or was it something that I could have done differently or thought about differently? I see this as being part of my ongoing learning and development.

In my experience, very few adolescents will completely address all possible therapeutic topics as adolescents, and may need psychological help at various stages across the lifespan. However, if they leave therapy now with a good impression of what a counselling psychologist has to offer, they may well be better informed and motivated for help again later in their life, possibly at a developmental transition, such as having children or being faced with parental death/illness.

References

- Davies, W. (2009). *The RAID course handbook*. Leicester: APT Press.
- Digney, J. & Gaffney, P (2006). What do you take in your tea? *Relational Child & Youth Care*, 19(4), 46–48.
- Fraser, J. & Solovey, A. (2007). *Second-order change in psychotherapy: The golden thread that unifies effective therapies*. Washington, DC: American Psychological Association.
- FIFA (2009). *The big count*. Retrieved 6 August 2009 from: fifa.com/worldfootball/bigcount/index.html
- Gardner, H. (1999). *Intelligence reframed: Multiple intelligences for the 21st century*. New York: Basic Books.
- Gilbert, P. (2009). Moving beyond cognitive therapy. *The Psychologist*, 22(5), 400–403.
- Hanos-Webb, L. (2005). *The gift of ADHD: How to transform your child's problems into strengths*. Oakland, CA: New Harbinger Press.
- Hayes, S.C., Strosahl, K.D. & Wilson, K.G. (2003). *Acceptance and commitment therapy: An experiential approach to behaviour change*. New York: Guilford Press.
- Hoyt, M.F. (2006). The temporal structure of therapy: Key questions often associated with different phases of sessions and treatments (plus 21 helpful hints). In W. O'Donohoe, N. Cummings & J. Cummings (Eds.), *Clinical strategies for becoming a master psychotherapist* (pp.113–125). San Diego, CA: Academic Press.
- Hubble, M.A., Duncan, B.L. & Miller, S.D. (Eds.) (1999). *The heart and soul of change: What works in therapy*. Washington DC: American Psychological Association.
- Lambert, M.J. & Barley, D.E. (2002). Research summary on the therapeutic relationship in psychotherapy. In J. Norcorss (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp.17–37). New York: Oxford University Press.
- Linehan, M. (1993). *Cognitive-behavioural treatment of Borderline Personality Disorder*. New York: Guilford Press.
- May, R (1983). *The discovery of being*. New York: W.W. Norton.
- Seligman, M.E.P. (2002). *Authentic happiness: Using the new positive psychology to realise your potential for lasting fulfilment*. New York: Free Press/Simon & Schuster.
- Selekman, M. D. (2005). *Pathways to change: Brief therapy with difficult adolescents*. New York: Guilford Press.
- Yalom, I.D. (2002). *The gift of therapy: Reflections on being a therapist*. London: Piatkus.

Correspondence

Dr Paul Gaffney

Senior (Clinical & Counselling)
Psychologist,
HSE Child & Family Clinic,
Drumalee Cross,
Cavan,
Ireland.
Tel: 00353 49 4377344
E-mail: paul.gaffney@hse.ie

Snapshots: Moments in time with children and families

Diane Hammersley

WORKING WITH children and families who are involved with the family courts may seem a long way from the usual therapeutic practice of building up relationships over time and bringing about gradual change. I am not always sure whether conducting assessments and writing reports as a jointly appointed and independent expert, produces much change or even whether it is therapeutic in the same kind of way. Certainly it may contribute to some kind of resolution of a problem situation or impasse, but the relationships are more formal, transitory and involve snapshots of a child's life rather than a video which includes more contextual features and a longer narrative. The psychologist 'zooms in' for the snapshot and just as quickly 'zooms out'. I do not always see the finished picture, but have to trust that those who make decisions about children's lives find the psychological report readable and informative.

These snapshots or moments in time may involve talking to children, playing with them, observing them with their parents and families or even surprisingly, never meeting them at all. Whether I see the child or not depends on the instructions from the court and the questions that are asked, which may in some cases be more about the parents. However, a case involving protection issues or contact is always about a child, over whose future I may have some influence, but until that child comes to review the album of snapshots of their lives when they reach adulthood, and reads my report and recommendations, they will never have met me and realised that I was part of their lives for a brief moment of time. The impact and responsibility of working for the unseen child is just as significant for me as those that I meet and know however briefly.

This paper describes a variety of ways of working briefly with children, within the context of the family court system, some of the complexities and difficulties that may be encountered and some of the ethical dilemmas which arise particularly those that result from trying to meet the expectations of instructing solicitors and the court system. It is also about my search for a distinctively counselling psychology approach which relies less on psychometric measurements and diagnostic criteria and uses a more qualitative and therapeutic style to assist the parents and families involved so that the child and family may benefit. Our legal system will only fund assessments and not therapy, but within that framework it is sometimes possible to bring about therapeutic change.

Talking to children

Finding out how children feel about their family situation and what they want to happen poses problems when the parents are divided and fighting over access or residence of the children. The conflict has often been going on for a considerable period of time before it reaches the courts, and children may have a stronger attachment to the parent with whom they have been living. Further, they often pick up on what that parent wants or expects of them even if there is not outright pressure put upon them to reject the non-resident parent. Loyalty to one or other parent may conflict with what a court may decide is the child's best interest (Children & Young Persons Act 2008). Recent developments in society's understanding of the role or rights of fathers have left the impression that children usually benefit from access to both parents, but that is not always the case and the quality of those

relationships is crucially important too (Smart et al., 2001).

All case examples have been anonymised and identifying details removed.

The Smith-Jones family

The four Smith girls had always lived with their father because after a very brief time together Mr Smith and Ms Jones always lived apart but seemed to reunite every few years to have another daughter. When Ms Jones could not cope with the toddler because she was dependent on tranquillisers, the girl would go to live with her sisters and father. They now ranged in age from 5- to 13-years-old. Ms Jones had applied to the court for the girls to stay with her in pairs every other weekend but Mr Smith was opposed to this. He seemed to say that he would co-operate but he had all the benefit money and he claimed Ms Jones did not feed them properly because her money was short. Then the older girl wanted to stay around home at weekends to visit her friends, the 8-year-old was in the gym club which father needed to take her to on a Saturday in his car ... and so it never seemed to work out properly. When solicitors got involved, they jointly asked for a psychological report to recommend how these parents could be helped to understand the needs of the girls for contact with their mother, talk to each other and sort it out.

Armed with plasticine, masks, colouring materials and covers for the solicitors' board-room table, my colleague and I spent two days interviewing the parents individually, and observing each of them with the girls in pairs before we interviewed the girls to ask them what they wanted. I planned to observe the dynamics of the girls' relationships with their parents and the dynamics of the parents' relationship to see if I could work out how to improve communications between the parents over contact. I drew upon attachment theory (Howe, 1995), object relations theory (Cashdan, 1988) and experience of working with children in settings such as schools and nurseries. It was to be a snapshot of the family interactions

over two days but what emerged were the shadows in the background which gave me greater cause for concern.

Mr Smith was about 20 years older than Ms Jones and he immediately told me that he had met her when she was a 'working girl' and I suspected he was implying that he had been her protector or pimp. That might have explained where the power was in their relationship and Ms Jones' anxious, timid and fruitless attempts to argue with Mr Smith. I observed he could easily destroy her arguments with his contempt. I then heard about the kind elderly 'uncle' who lived near to father and sometimes 'babysat' the girls when father was out.

On the second day I was presented by the solicitor with several recordings of telephone calls made to Ms Jones by a young female voice who made playful remarks of a slightly suggestive nature. The eldest daughter agreed that she had made the calls 'just for fun' but her flirtatious yet affectionate interaction with Mr Smith left me concerned about the suitability of her living with her father and sisters and having little contact with her mother. The interviews themselves revealed that the girls were fond of both their parents, but the conversations revealed much more in the shadows than I had anticipated.

This example illustrates how the presenting issue of difficulties over contact arrangements may conceal more complex interpersonal dynamics of abuse and power. There are also unexpected revelations which a child may make or which are hinted at in the process. Here I was concerned about the flirtatious nature of this daughter's telephone conversations and what it might mean about her relationships with her parents. The solicitors may be expecting me to come up with a definitive answer which I cannot give. I was also concerned about the suitability of their babysitter, and having to hold back from making unreliable guesses about what might or might not be happening. I am sometimes asked for an opinion explicitly but more often it is these suspicions which have led to the request for a psychological

opinion in the first place. Child protection work involves the parties acknowledging their suspicions but not jumping to conclusions without firmer evidence.

Playing with children

Play therapists work with children over a period of weeks or months but play sessions can be used as snapshots of children's emotional state or relational attachments, as another way of trying to build up a picture of children's lives. This is an account of some play sessions used with a boy of about 4-years-old.

Eric was seen as part of an assessment of his estranged parents because they were in dispute over contact. He lived with his father and his new partner because when he was 2-years-old both his heroin-addicted parents were neglecting him and he went with his father to live with his paternal grandmother. Eric had shown signs of aggressive behaviour at nursery school and bed-wetting and he seemed to be psychologically troubled. I had arranged to observe him playing with his mother and then with his father before I saw him with his Guardian *ad litem*, but the plan did not work out without difficulty. When I went to the waiting room to collect Eric he clung to his father's leg and would not let go or speak to me, so I asked his father to bring him in and then leave us. It seemed to me that the father was really clinging to the child more than the child was clinging to the father and that the relationship was one of symbiotic attachment.

In our session with his Guardian as observer, I invited Eric to use the plasticine and make models, to draw with the crayons and to make up stories with the range of soft toys I use sometimes. He did all three. His drawing of his house seemed to have its full complement of windows and doors and chimneys but the violence and aggression around the outer part of the house and the black scouring of the page along with his commentary seemed to relate to a dispute that Eric knew about when his father repeated accused his mother of coming

round to his house and slashing the tyres on his car. Bach (1990) employs similar analytic methods in interpreting drawings of children who are severely ill.

Then the toys provided him with the means to tell me a story about the animals being transported in a truck in cages that were locked and for which only the driver had the key. As the story progressed, it became more and more frightening and aggressive until Eric chose the seal the smallest and palest of all the toys to whisper in my ear. There were no words, just a sense that the seal needed to tell somebody something that was a secret. I got no further than a sense of how he might have felt when he was little, and he was sometimes locked in when his parents were injecting drugs.

Some weeks later I was asked to have another play session with Eric and to meet his parents, the Guardian and all the legal representatives afterwards to discuss what I thought about Eric. There was no set plan and I had no time in between the session and the meeting. I find that being completely honest about my feelings and concerns about the child and tentative about my interpretations without making grand statements is usually more helpful in these kinds of meetings. I do not need to know with certainty or show off my psychological insights, and it is perfectly acceptable for me to say if I cannot answer their questions. The purpose is really to break a deadlock or move the process on in some way which all parties can agree to.

We met in a CAFCASS family room which was very well equipped with sand trays, drawing materials and toys. CAFCASS is a Government agency who looks after the interests of children involved in family proceedings. When I went to collect Eric from his father, he rather sheepishly pretended not to want to come at first, but then walked into the family room with me. He promptly bolted into the corner and hid behind the cupboard. I got a sense that he had made his point that he was pretending to treat me as if I might be a threat but was not really frightened and soon came out.

He played with the sand tray covering things up under mounds of sand but soon moved on to playing with Lego, dismantling vehicles and building walls round them on all four sides. He was talking to me much more this time about his play and giving me a commentary of what he was building. I was struck by the angry dismantling of vehicles which were somewhat ironically all emergency support vehicles. He then picked up a Russian babushka doll, a grandmother with another doll inside another. I thought that Eric has a lot which is hidden which needs to be revealed and that angry feelings and violent behaviour have played a large part in his life so far. Maybe he needed saving and emergency support. This kind of interpretation draws upon understanding the symbolic nature of play and I envisaged longer term play therapy might help him talk about it.

Observing children in a nursery

There are two different ways in which I observe children; on their own or with another family member. It might be something about the child that the courts want me to observe or a relationship with a relative that they want me to evaluate and comment upon. Observation is part of assessing a child's development and possible abuse (O'Hagan, 2006). I now realise that the request to observe is in reality a hope that I will discover something and that hope is often based upon a suspicion which is unspoken as with the Smith-Jones family.

I was asked to assess James' mother for a lot of issues, including cognitive functioning, history of abuse, mental health and her parenting skills. Since his mother Laura was an adult, I was a little puzzled about being asked to assess her relationship with her parents and the dynamics within the family. Since Laura had had two other children who were looked after by their father, I wondered whether Laura's parents were being considered as carers for James. I was asked to assess the attachment between Laura and her son James, which meant I should probably observe them together.

After the first day of assessment I arranged to observe contact between Laura and James who was with temporary foster carers, at his day nursery. At the time I did not know that Laura had been effectively banned from the nursery and I could not see them together there. So I saw James for the first time arriving with his escort and when he was introduced to me I noticed that his gaze was just like his mother's, blank and unemotional and that he was not the least bit interested in me, but went off to play. He seemed emotionally cut off and disengaged and I wondered whether he might fit a diagnosis on the Autistic Spectrum. The nursery head immediately invited me into her room and sat me down to give me her concerns about James who she regarded as 'seriously disturbed'. It then became clear to me that Laura's father was suspected by them of sexually abusing James and that might have occurred with Laura and explain some of her strange behaviour too. It was apparent that the staff were pleased to have got a psychologist in at last and were hopeful that I would make an immediate diagnosis of sexual abuse. I had barely met James.

I was very aware that investigations were being made by specialist police officers and forensically-trained interviewers and that I had to be extremely cautious about where my detective work was likely to take me. I was also aware that I was probably going to disappoint the nursery staff and many other people who hoped I would uncover something about why James seemed disturbed and had originally run off from his mother. A snapshot is never the whole picture.

I chose to sit in an area of the playroom which meant that all the children could see me and know I was there but also meant I did not interfere with their activities, and waited. Several of the children approached me and talked about what they were doing and a few brave ones asked who I was and whether I had come to see James. James played alone, frequently putting play dough into his mouth. I did not intervene and he came up to me once and spoke but I could

not understand what he said. During the story time and drinks session, he sometimes lay on the floor ignoring what his teacher was doing and the other children. Outside he ran about and climbed freely but did not interact with any of the other children.

Whatever had happened in that family, it is all too easy to make assumptions and jump to conclusions. I left the question of sexual abuse to the police investigations but did recommend that James and his mother might be assessed for learning disabilities or autism, which were not confirmed. However, this snapshot could not be the whole picture and I recognise that the cycle of poverty and deprivation may lead to all kinds of abuse including psychological and emotional abuse (Pritchard, 2004).

Observing children in their family context

I had assessed the parents and grandmother of Angelina a year before and observed contact between her and her mother then, but at the final hearing which would decide Angelina's future, the question of her attachments to all the members of her wider family was raised. If she was placed permanently outside the family, how would that be likely to affect her? Although it was likely that she could not be looked after by her parents or relatives, they had all got used to very regular and extensive contacts.

I observed Angelina on four occasions in one week and did not really interact with her as she chose not to talk to me at all, but signalled her greeting to me with a hand gesture. So I was the proverbial 'fly-on-the-wall' in contact centres and homes. It was immediately apparent that the family members were all trying very hard to impress me and I felt a little uncomfortable that I was not going to be paying any attention to that but to whether Angelina appeared to be attached to them in accordance with my instructions (Howe, 1995). In many cases where children have supervised contact with parents, observations are recorded by 'contact workers' employed by social services

who write descriptions of what occurs and sometimes make statements about the quality of the encounter based on whether the child seemed happy rather than the quality of the relating.

She played and performed as her family required her to but there were no conversations of any note or length. It was all frantic activity and shouted questions which seemed to be focussed on the needs of the adults rather than the needs of the child for opportunities to relate to her relatives. At the beginning of the week I had met Angelina with her foster carers and the contrast was quite marked. I thought Angelina was more attached to her carers and to the other children in the family than any of the adults. She lived in a child's world of 'make believe'. In spite of only seeing Angelina for a week, I had seen her in the previous year and knew her life history in some detail. I looked for signs of a secure child who seeks proximity with a carer and calmness rather than a frantically excited one.

The unseen child

Sometimes I am assessing parents and do not meet the child at all, but nevertheless I am still concerned with acting in the best interests of the child. The problem is often that the child could best be protected by working with the parents but for a variety of reasons, that does not happen. We need to recognise that our psychotherapeutic services which include addiction services are sometimes not able to work at sufficient length, depth or intensity to promote sufficient healing for those who have been damaged in childhood and so the problems and hurt are passed on to the next generation.

Quite often parents whose children are being protected deny that their past lives have any significance in the present circumstances. Jacobs (2006) makes the connection between the parent's past experience of abandonment and present difficulty trusting, past experience of rejection and present feelings of shame and guilt, past experience of dominance and submission in

present acts of sadism and masochism. Domestic violence has come to public attention recently and there are concerns for the effect upon children. Sutton (2008) makes the point that the combined effect of witnessing violence and secondly that violence being perpetrated by one person on whom the child is dependent upon another person on whom they are also dependent produces a sensory assault which is profoundly damaging.

Another major area of concern is that of drug-addicted parents. Kohut (1977) states that the addict craves the drug because it seems capable of curing the central defect in his self, and becomes a substitute for the self-object which failed him. Winnicott's (1971) concept of the transitional object is what mothers allow and expect their infants to become 'addicted' to, an attachment. So the drug is a transitional object with important tension-regulating functions but unlike attachment to a good-enough parent, it does not promote autonomy. Weegmann and Cohen (2002) in exploring the dynamics of drug use address the issue of deprivation when the person is handicapped by the original deprivation inflicted on him or her, and then builds up defences such as aggression, denial and so forth to block out the pain and then a layer of drug use in response to the emotional pain.

Conclusion

These snapshots are moments in time and can never be seen as the whole picture. They are often moments of extreme suffering between parents with good intentions being separated from the children they have borne. They represent the efforts of people who are attempting to heal a child, a broken family, or a social disaster from within a legal framework which may not be best suited to

the task. What is often needed is some form of family therapeutic work, because working with the parents if they are willing and ready will usually benefit the child. It is usual to recommend that, and in the process of the assessment increase the motivation of the parents to seek and accept help which they might otherwise have viewed with suspicion or disdain. Looking at these snapshots is sometimes frustrating, frequently painful and since I rarely know the final outcome, taken in the hope that they may make a difference.

I have attempted to show in this paper that a distinctively counselling psychology approach has much to offer to the family courts for a number of reasons. First, it is important to recognise that a qualitative methodology which allows for intuitive knowing, practice-based evidence, and openness to what may be present that has not previously been known is valuable. Second, in spite of my engagement being a moment in time, I believe that I do some good because of my essentially therapeutic style. Family members often comment that the assessment has in one sense been much more painful an exploration than they anticipated or previous assessments, but has moved them to understand themselves better. Third, since the report has to stand up to being tested in a court hearing, and from feedback from solicitors, I believe that this approach is well-respected and valued by other professionals who do not necessarily understand or value some of the dense jargon-laden reports that they are used to from psychologists.

Correspondence

Dr Diane Hammersley

Independent practice.

E-mail: diane.hammersley@googlemail.com

References

- Bach, S. (1990). *Life paints its own span: On the significance of spontaneous pictures by severely ill children*. Einsiedeln, Switzerland: Daimon Verlag.
- Cashdan, S. (1988). *Object relations therapy: Using the relationship*. London: W.W. Norton & Co.
- Howe, D. (1995). *Attachment theory for social work practice*. Hampshire, UK: Macmillan Press.
- HM Government (2008). *Children and Young Persons Act*.
- O'Hagan, K. (2006). *Identifying emotional and psychological abuse: A guide for childcare professionals*. Berkshire, UK: Open University Press.
- Jacobs, M. (2006). *The presenting past* (3rd ed.). Berkshire, UK: Open University Press.
- Kohut, H. (1977). *The restoration of the self*. New York: Int.U.P.
- Pritchard, C. (2004). *The child abusers: Research and controversy*. Berkshire, UK: Open University Press.
- Sutton, A. (2008). A child psychiatry perspective: Children as victims of adult-adult violence. In J.Keeling & T. Mason (Eds.), *Domestic violence*. Berkshire, UK: Open University Press.
- Smart, C., Neale, B. & Wade, A. (2001). *The changing experience of childhood: Families and divorce*. Cambridge: Polity Press.
- Weegmann, M. & Cohen, R. (2002). *The psychodynamics of addiction*. London: Whurr Publishers.
- Winnicott, D.W. (1971). *Playing and reality*. London: Routledge.

Building resources and resilience: Why we should think about positive emotions when working with children, their families and their schools

Julia Hutchinson & Veronica Pretelt

Recent research in the field of positive psychology emphasises the important role positive emotions play, not only in overall human well-being, but also in the development of resilience. In this paper, we use Barbara Fredrickson's 'broaden and build' theory of positive emotions (Fredrickson, 2003) to explain the importance of generating positive emotions in the therapy room in addition to attending to the problems that our clients bring. We illustrate this with some examples of school-based therapeutic group work which aims to build and cultivate resilience through an 'upward spiral' of positive emotions. These examples also demonstrate the importance of including the child's community in this work: their family, peers and school.

'Treatment is not just fixing what is broken; it is nurturing what is best'.

(Seligman & Csikszentmihalyi, 2000)

AS PRACTITIONERS working with children resilience has been an important issue, ever since Michael Rutter first highlighted ideas around continuity and change in children and young people's developmental pathways and the possibility of positive outcomes despite poor maternal attachment (Rutter, 1981; Rutter & Rutter, 1992). Often those we see are struggling with layers of adversity: experiences of trauma and abuse, a loss of key attachment figures, poverty and educational underachievement. However, the recent upsurge in thinking and research in positive psychology and the realisation that a large proportion of children survive and indeed thrive despite challenging contexts and barriers (Masten & Reed, 2005), has enabled us to use the research base to think about how we can work at a preventative level. Through our work we aim to encourage children to develop and practise skills that will equip them to cope with and recover from adversity. We believe that being playful as well as serious, laughing as well as crying, encour-

aging calm and relaxation as well as exploring fearful emotions, are important aspects of successful therapy. Humour, serenity, trust, appreciation and compassion are positive emotions that are not only important in interrupting problematic and unhelpful cycles of interaction between children and the people who matter to them. They are also vital in helping to build and practise resilience.

We work for a small children's charity in London, offering a counselling and therapy service to children and their families. We work primarily from a social constructionist framework, and would like to give readers a taste of what work with children within this setting and from this approach can look like. We believe that counselling psychology, coming as it does from a humanistic value-base, and with an emphasis on life-span development and a focus on well-being rather than sickness (Woolfe, 1996), is particularly well-placed to grapple with ideas such as resilience and to integrate research and theory from positive psychology. In this paper we attempt to outline the importance of positive emotions in promoting resilience and demonstrate how we keep this in mind when working with children. Firstly, we will

present some of Barbara Fredrickson's research on positive emotions; in particular the 'broaden and build' theory (2003, 2005). We will then link this theory to the work we do by sharing specific examples from 'Mighty Me', one of our school-based therapy groups. 'Mighty Me' is a nine-week programme for primary-aged children who are living with problem-saturated identities and struggling with problems like bereavement, bullying, experiences of abuse and their resultant 'effects'¹. Finally, we highlight the importance of taking this work outside the group context to build resilience within the wider community as well.

Positive emotions and resilience building

Thus far, most research on emotions has revolved around the impact that negative emotions have on both our ability to survive under extreme threat and our mental health. Central to the definition of a 'negative' emotion is the idea of a 'specific action tendency' (Fredrickson, 2005). Negative emotions, as they are called in the literature, like fear and anger, help to prepare us physically and psychologically to act in a particular way. 'Negative' in this sense does not mean 'bad'; indeed we have for a long time now known that under adversity negative emotions can be crucial for survival as they gear our physiological systems to a flight or fight mode. It is also worth noting that the survival attributes of negative emotions are not always short lived. Anger, for example, can be an effective motivator on an individual and societal level, sparking change in the face of abuse and cruelty. More recently, research and theory has started to uncover how positive emotions go far beyond their purely hedonistic qualities and to highlight their importance in building resilience. Fredrickson has posited a 'broaden and build' theory to elucidate this role (Fredrickson, 2003, 2005). Positive emotions

speed recovery as 'undoers' of the associated arousal and narrowing of attention within the nervous system that comes about with negative emotions (Fredrickson & Levenson, 1998). Positive emotions restore physiological activation to levels prior to the kinds of physiological arousal associated with stress responses (that is, flight, fight or freeze) and re-establish psychological openness to a broader range of possible actions. So just as negative emotions have survival attributes – if threatened, high arousal and narrow attention are adaptive – so positive emotions have a complementary role to play as 'undoers' of negative emotion and in broadening momentary thought-action repertoires. The experience of joy, for example, broadens our repertoire of action by encouraging us to play, to create, to push limits and explore the world around us. Furthermore, when we play we relate to others and build social bonds. When we push our limits and explore the world around us we not only enhance our sense of personal agency, we also gather new information about our environment. All of these in turn, become adaptive features that will help us in the future when dealing with adversity.

The repeated broadening of attention and thinking that comes about through the momentary experience of positive emotions enables us to discover and build personal resources at a physical, psychological, intellectual and social level that are enduring (Fredrickson, 2003) and lead to improved resilience. For example, childhood play and the positive emotions it brings about, builds personal resources in several ways. Most obvious are physical resources: strength, agility and co-ordination. Social resources are also developed through shared smiles and fun, building strong bonds and attachments (Rogers & Sawyer, 1998, as cited in Cole-Hamilton, Harrop & Street, 2002; Simons, McCluskey-Fawcett & Papini, 1986, as cited in Fredrickson, 2005). Intellectual

¹ This group is based on a programme originally developed in Australia by Rosie's Place for children who have experienced sexual abuse (Want, 1999).

resources develop by creating problem solving skills and learning new information; and psychological resources are developed through optimism, a sense of identity and goal orientation (Fredrickson, 2003; Rogers & Sawyer, 1998, as cited in Cole-Hamilton, Harrop & Street, 2002). The more we practise playing, and experience the momentary positive emotions and broadened attention this brings, the more these resources are built and endure. This 'broaden-and-build' theory predicts an 'upward spiral' whereby positive emotions and the broadened thinking associated with it will help build lasting personal resources influencing each other in a reflexive way. Positive emotions lead to increased resources which in turn lead to more positive emotions and so on (Kok, Catalino & Fredrickson, 2008). Thus, frequent positive emotions are seen as keys for the development of future well-being (Fredrickson et al., 2008)².

In addition, experiencing positive emotions within the context of managing difficult, stressful or traumatic situations, like those in which our clients find themselves, is also helpful. Research with adults has found that those who experience positive emotions in the midst of bereavement are more likely to develop long terms plans and goals and more likely to find positive meaning in their distress (Moskowitz, Folkman & Acree, 2003). The experiencing of positive emotions also helps to break the cycle of prolonged negative affect that without respite can lead into a downward spiral of depression (Gross & Munoz, 1995). So experiencing positive as well as distressing emotions and thoughts within difficult times, helps people cope with adversity and improve the possibility of emotional well-being and coping better in the future (Fredrickson, 2005). Folkman and Moskowitz (2000) describe three different kinds of coping that enable individuals to generate and sustain positive affect in the context of chronic stress: positive reappraisal

(reframing a situation to see it in a positive light), goal directed problem focused coping (efforts directed at solving or managing a problem through identifying realistic goals, internal resources and small acts of mastery over the difficult situation) and infusing ordinary events with positive meaning (identifying what people have done that has been helpful or which relates to something they give value to).

'Mighty Me' and the 'upward spiral'

In our work we have been grappling with the questions of how we can encourage this 'upward spiral' of positive emotions. Within the framework of narrative and solution oriented therapy with children, through the use of play, art and a vivid imagination, we implement strategies that give rise to feelings of personal agency, serenity, mirth and appreciation for others. Equally important, we aim to create opportunities for children to problem solve by generating realistic goals and identifying internal and external resources. We will illustrate how we are attempting to do this within the context of one of our primary school-based group work programmes, 'Mighty Me'. We will demonstrate how three of the activities we use in this group aim to broaden repertoires of action and build personal resources that will lead to an 'upward spiral' experience for the children and those around them. Most of the change that happens is conceptualised within a social context so that these positive emotions can 'resound through others' (Fredrickson, 2003) transforming not only the children but their families and school communities as well. Parallel to the work we do we are always bringing external voices into the room (teachers, family and friends) enabling us to build a community in which children experience a sense of interconnection and oneness with significant others. It is, however, important to note, that whilst introducing a context in which positive emotions can reverberate amongst the group

² Please see Fredrickson, 2003 for research evidence for the broaden, build and undoing hypotheses.

members, firstly, a safe forum in which children can openly speak about the sorrows, fears and pains they bring with them needs to be created. During the group process, close attention is paid to making sure children can name and understand their negative feelings so that these can be both normalised and validated. It is precisely this back and forth between negative and positive emotions that allows children to safely explore and more easily withstand some of the emotional pain they bring with them.

Interviewing the problem

One key ingredient in 'Mighty Me' is naming and externalising the problem³. This is a process by which we give human-like characteristics to the problem so externalising it and therefore enabling the child to perceive that the problem is separate from him/herself, and consequently, that s/he can have some influence over it (White & Epston, 1990). This is a type of goal-directed problem focused coping exercise as outlined earlier in Folkman and Moskowitz (2000).

One way in which we externalise in 'Mighty Me' is through 'Interviewing the problem'. One child acts out the relevant problem, be that temper, shyness, sadness, distraction, while another acts the role of a TV interviewer. The rest of the children in the group are the TV audience. Props help to set the scene and a few set questions from us help to start the interview off (for example, 'How come you are hanging around?' 'What do you get out of bothering people?'). The interviewer and the audience then call out questions of their own, helping to uncover the problem's tactics and to discover what makes the problem smaller. High hilarity often ensues, but the point is that we are talking with the children about things they often find hard to talk about, in a fun way, thus undoing most of the associated negative arousal that thinking about the problem directly could generate.

We think that the fun, playfulness, creativity, laughter and joy that this exercise generates, broadens attention and helps the children to build resources to manage the problem differently. Intellectually they find ways to think differently about the problem (cognitive reappraisal): 'I am separate from this problem; I can influence it; I can make it smaller; perhaps it is not as powerful as I believed; other people have difficult problems too'. They can also find different ways to manage it (problem focused coping): 'I can talk about this problem and it does not like that; I can ignore it; I can ask for help with it; I can remember all the things I can do that it can't'. In addition, we believe the experience of this within a group of peers is key as it builds social resources: the shared bonds and memories of tackling something difficult together encourages the 'upward spiral' as the positive emotions this generates resonate within the group.

Mighty check-in

One of the weekly rituals in 'Mighty Me' is the mighty check-in. This is an opportunity for children to share with one another ways in which they have been mighty throughout the week. Mightiness has been defined within the group as the ability to be 'strong in our heads and in our hearts'. This will include behaviours that have been previously identified as small acts of mastery within chaotic situations, behaviours that lead to preferred futures and ways of being and times in which the children defy their problem saturated stories. The check-in is also a chance to share small acts of joy and kindness which lead to the infusion of positive meaning into ordinary events (Folkman & Moskowitz, 2000). The children, therefore, engage in a daily exercise of noticing small and large acts of mightiness. This continuous noticing leads to an increase in mighty behaviours due to the children's desire to collect stories to share with the

³ The solution-focused and narrative elements of 'Mighty Me' are described elsewhere (Hutchinson, Yusuf & Pretelt, 2007).

group as well as the positive feelings (for example, pride or happiness) that are elicited by these acts and engendered by sharing them. The mighty check-in also gives children the opportunity to practice naming their feelings as well as remembering that they can have positive feelings and experiences within moments of distress. Slowly this process allows us to see a shift from a problem-saturated view of self to a stronger, happier more influential self. Children build on their acts of mightiness as well as learn from other members' examples. It has come to our attention after six years of running this group, that in addition to sharing examples of times in which they have related differently to the identified problem, most examples of mightiness are small acts of compassion towards others. The children begin to engage in selfless acts such as giving another their spot in the queue, or allowing a sibling to have control over what programme to watch on TV. This eventually leads to a resounding effect on those at the receiving end, improving relationships and leading to a forward chain of kindness and compassion.

As the group progresses, we have noticed a natural inclination from the children to share stories of times in which they have noticed each other being mighty. It is fascinating to observe how in those moments in which a particular child might struggle to find an example of mightiness, other children will be jumping up with excitement to share ways in which they have noticed their group mate being kind, caring or strong. This immediately leads to very natural strengthening of social bonds between the group members. We run this group jointly with a member of school staff who, among many other roles, has that of noticing and looking out for acts of mightiness throughout the week and collecting feedback from teachers and other school staff. We also have tried different ways of gathering feedback from parents. As a result, we have several voices that will reinforce the children's behaviour and celebrate their acts

of mightiness, contributing to the previously mentioned 'upward spiral' phenomenon.

Letters to supporters

Before the group begins we will have a meeting with teachers, parents and children to identify their best hopes for the group. This also gives us an opportunity to identify ways of thinking and behaviour that will help the children achieve their preferred futures. Crucial in this process are the letters to supporters. This is an exercise in which children write a letter to significant others (parents, siblings, best friends, teachers, grandparents, etc.) asking them to notice specific ways of being they would like to engage in. Firstly, this is a very special and enjoyable activity in which they will write and decorate these cards using their imagination and creativity. There is huge excitement and anticipation as these letters are stamped and posted. The children express gratitude to those they love and identify a support network outside the group who will help the child in their endeavour to make the influence of problems smaller in their life. We have noticed how this activity increases the likelihood children will engage in more of these positive behaviours and ways of thinking as they are repeatedly encouraged by significant others. It is through this constant recognition of effort that they find most strength. We have noticed a knock-on effect in which the wider community begins using this 'mighty' language asking other family members to also notice the efforts they are making; a continuous reciprocity of acknowledgment begins to develop within the family nucleus. We recently had a parent tell us how much emphasis her son had put on them noticing times when he was more helpful and patient at home. As they perceived the positive effect their noticing had on his behaviour, they began to ask one another as a couple and as parents to notice their own acts of mightiness. This we believe is a lovely example of the reflexive element of the 'broaden and build' theory. The positive emotions elicited by the loving support

they received by significant others, led to a broadening of ways of behaving that contradicted the problem-saturated stories. These then helped build further personal resources such as stronger bonds and support network, new ideas on how to make problems smaller and a more harmonious lifestyle.

The ‘resounding’ effect

As mentioned earlier, a hugely important part of ‘Mighty Me’ is to find ways in which we can encourage this ‘resounding through others’, and thus the ‘upward spiral’. Further to the already mentioned examples, we produce a series of public documents that serve as entry points for the wider community. The ‘Graffiti Wall’ and a booklet on ‘how to make problems smaller’ are ways in which the children share with other children outside the group strategies to cope with difficult situations. We have end of group meetings with staff and families in which we share the success children have had in influencing the problem. There are further projects to involve previous group participants in training teachers and other staff members in the basic principles of noticing acts of mightiness and externalising problems. In one school, children have continued to meet in ‘Mightier Me’ and ‘Mightiest Me’ to remember and practice what they have discovered. In this school, the head teacher commented on a significant decrease in playground violence and an increased ability of the ex-‘Mighty Me’ children to reflect on their behaviours, to apologise and to repair any hurt they might have caused. This really is social resource building! And in fact, it is in the schools where ‘Mighty Me’ has run several times and has become so much a part of the culture of the school, that we have really noticed the ‘upward spiral’ to best effect. This is helping both individuals and schools to build and practise resilience.

We should note at this point that the evidence for good outcomes from ‘Mighty Me’ is derived from practice rather than from large-scale nomothetic studies.

Children, parents and teachers tell us ‘Mighty Me’ works as the group progresses and in more formal evaluation at the end of the group. It is interesting that in the absence of what we might think of as more ‘scientific’ or ‘objective’ outcome measures, such as a randomised controlled trial, and even within today’s climate, the group is in high demand and we cannot fulfil the service requests for the group due to our staffing levels. This is especially true of the schools where ‘Mighty Me’ has run several times, as noted earlier. Commissioners of the group, usually the head teacher, notice how children and the people around them adopt ‘Mighty’ ways of thinking and doing, and that these helpful ways of managing problems have real effects. We do need to measure these effects in more formalised ways, however, and have piloted outcome measures for two groups so far. We are currently thinking of how we can address the challenges associated with this type of measurement. For us these include relatively low subject numbers, ethical issues around wait-list controls, the time available in a small and very busy charity funded for direct work, ensuring teachers and parents with whom are contact is more limited to fill out measures, to name a few.

Conclusion

‘We should work to cultivate positive emotions in ourselves and in those around us not just as end states in themselves, but also as a means to achieving psychological growth and improved psychological and physical health over time’ (Fredrickson, 2005, p.120). It behoves us as practitioners to language our conversations with children in ways that promote positive development and resilience, to beware of what we focus on and what we decide to give attention to, and to understand the influence we have so we can use it wisely. In this work we are trying to increase the likelihood that opportunities for positive emotions will occur, while co-creating and remembering ways of coping that elicit and sustain positive emotions thus

providing broadening mindsets that will build social, intellectual, psychological and emotional resources in children. We also have to help create contexts where not only children can experience positive emotions but communities in which their parents, siblings, teachers, and friends can do so as well. Positive emotions transform communities as well as individuals (Fredrickson, 2003). Through the small but frequent acts of mightiness the children share in the group, they elicit and experience positive emotions that not only help them to build resources and resilience, but help their communities to become stronger and more cohesive.

As counselling psychologists a key focus in our work is linking theory, research and practice. In this article we have tried to bring together new research and theory in positive emotions and resilience and show how we practise this with children in our day-to-day work.

The authors

Julia Hutchinson

Chartered Counselling Psychologist and
BACP Accredited Counsellor,
West London Action for Children.
E-mail: julia.hutchinson2@btinternet.com

Veronica Pretelt

BACP Accredited Psychotherapist,
West London Action for Children.
E-mail: veronicapretelt@gmail.com

Correspondence

Julia Hutchinson

References

- Folkman, S. & Moskowitz, J.T. (2000). Positive affect and the other side of coping. *American Psychologist*, 55(6), 647–654.
- Fredrickson, B.L. (2003). The value of positive emotions. *American Scientist*, 91, 330–335.
- Fredrickson, B.L. (2005). Positive emotions. In C.R. Snyder & S.J. Lopez, *Handbook of positive psychology*. New York: Oxford University Press.
- Fredrickson, B.L., Cohn, M.A., Coffey, K.A., Pek, J. & Finkel, S.M. (2008). Open hearts build lives: Positive emotions induced through loving kindness meditation, build consequential personal resources. *Journal of Personality and Social Psychology*, 95, 1045–1062.
- Fredrickson, B.L. & Levenson, R.W. (1998) Positive emotions speed recovering from the cardiovascular sequelae of negative emotions. *Cognition and Emotion*, 12, 191–220
- Gross, J.J. & Munoz, R.F. (1995). Emotion regulation and mental health. *Clinical Psychology Science and Practice*, 2, 151–164.
- Hutchinson, J., Yusuf, D. & Pretelt, V. (2007). ‘Mighty Me’: Problem free and solution full. *Counselling Children and Young People*, March, 22–25.
- Kok, B.E., Catalino, L.I. & Fredrickson, B.L. (2008). The broadening, building, buffering effects of positive emotions. In S.J. Lopez (Ed.), *Positive psychology: Exploring the best of people: Vol. 3 Capitalising on emotional experiences* (pp.1–19). Westport, CT: Greenwood Publishing Company.
- Masten, A.S. & Reed, M.J. (2005). Resilience in development. In C.R. Snyder & S.J. Lopez, *Handbook of positive psychology*. New York: Oxford University Press.
- Moskowitz, J.T., Folkman, S. & Acree, M. (2003). Do positive psychological states shed light on recovery from bereavement? Findings from a three-year longitudinal study. *Death Studies*, 27, 471–500.
- Rogers, C. & Sawyer, J. (1998). Play in the lives of children. National Association for the Education of Young Children. Cited in Cole-Hamilton, I., Harrop, A. & Street, C. (2002), *Making the case for play: Gathering the evidence*. London: National Children’s Bureau.
- Rutter, M. (1981). *Maternal deprivation reassessed* (2nd ed.). Harmondsworth, Middlesex: Penguin.
- Rutter, M. & Rutter, M. (1992). *Developing minds: Challenge and continuity across the life span*. Harmondsworth, Middlesex: Penguin.
- Seligman, M.E.P. & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, 55(1), 5–14.
- Simons, C.J.R., McCluskey-Fawcett, K.A. & Papini, D.R. (1986). Theoretical and functional perspective on the development of humour during infancy, childhood and adolescence. In L. Nahemow, K.A. McCluskey-Fawcett & P.E. McGhee (Eds.), *Humour and ageing* (pp.53–77) San Diego, CA: Academic Press. Cited in Fredrickson, B.L. (2005), *Positive emotions*. In C.R. Snyder & S.J. Lopez, *Handbook of Positive Psychology*. New York: Oxford University Press.
- Want, C (1999). *Adventures in groupwork*. Sydney: Rosie’s Place.
- White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton.
- Woolfe, R. (1996). The nature of counselling psychology. In R. Woolfe & W. Dryden (Eds.), *Handbook of counselling psychology*. London: Sage.

Mellow Babies: A group intervention for infants and mothers experiencing postnatal depression

Christine Puckering, Emily McIntosh, Anne Hickey & Janice Longford

Maternal postnatal depression has been associated with both short- and long-term negative effects for the child's emotional, social and cognitive well-being (Murray & Cooper 1997; Halligan et al., 2007). Therapies that focus on supporting mothers have shown accelerated improvement in maternal well-being, but few positive effects for infants (Cooper et al., 2003; Murray et al., 2003). Where interventions focus on addressing mother-infant interaction there appears greater chance of benefit to both mothers and children (Poobalan et al., 2007).

A small waiting list controlled trial of a 14-week Mellow Babies group intervention was carried out with 17 mothers and infants under one year. Mellow Babies aims to promote both mother-infant interaction and maternal well-being. Changes in maternal depression (Edinburgh Postnatal Depression Scale) and the quality of mother-infant interaction (video observation) were assessed.

Maternal mood in mothers attending Mellow Babies improved, with a significant difference in EPDS scores, relative to the control group, at follow-up. Post-intervention, there was a significant difference in levels of positive interactions between groups, favouring mothers attending Mellow Babies. The difference in negative interaction between Mellow Babies and waiting-list control group approached significance, with less negative interaction observed between mothers and infants who attended the group. Participant feedback on the content and process of Mellow Babies was highly positive.

The study showed benefits from Mellow Babies for mothers and infants who had exposure to postnatal depression. Further studies with longer-term follow-up and infant outcome measures may substantiate these initial findings.

POSTNATAL DEPRESSION is estimated to affect 10 to 20 per cent of women, with around 70,000 women and their families suffering the effects in the UK each year (Glover et al., 2002; Cooper et al., 2003; Royal College of Midwives Survey, 2007). A number of authors (e.g. Halligan et al., 2007; Puckering, 2005) highlight that in relation to the welfare of mothers, postnatal depression does not differ in quality from depression at any other life-stage. It is greatly distressing but can often be relieved through various approaches. The critical, unique characteristic of postnatal depression is, of course, the presence of the infant and the many reports of potential adverse short and long term effects for the child's emotional, social and cognitive development (e.g.

Murray & Cooper, 1997; Halligan et al., 2007). Thus this difficulty can potentially impact two generations and represents a significant public health concern (SIGN, 2002; NICE, 2007; Poobalan et al., 2007).

It is recognised that women experiencing postnatal depression can experience extra obstacles in relating to their new baby (Glover et al., 2002; Murray et al., 1996; Field et al., 1990). Mothers with depression show more negative and fewer positive responses to their babies (Puckering, 2005). Glover et al. (2002) describes how mothers may be withdrawn, with little smiling and talking to their infant; or they may be overly intrusive and rough in handling their baby. In response babies can become distressed with prolonged crying or withdrawn and passive (Glover et al., 2002).

These effects begin early: studies have shown that as early as two to three months infants will accommodate to maternal style, in a process of taking the best from the environment. Two- to three-month-old infants of depressed mothers, in face-to-face situations where mothers were asked to make their faces go still, failed to show the disengagement and distress common in babies of well mothers. They had accommodated to a muted pattern of interaction (Cohn & Tronick, 1983; Field et al., 1990). These effects begin early and can persist with attunement between the mother and infant becoming disrupted.

Associations have been found between postnatal depression and adverse emotional/social and cognitive functioning in later infancy, around 12 to 21 months (Murray & Cooper, 1997). Stein (1991) rated the quality of mother-infant interactions between mothers and their 19-month-old children. Where there was a history of postnatal depression infants showed less affective sharing, a lower rate of interaction, less concentration and more negative responses and were less sociable with strangers. This relationship was still found where the postnatal depression had remitted. Where mothers experience postnatal depression, a number of studies evidence poorer cognitive development in boys (Murray, 1992); higher levels of insecure attachment (Lyons-Ruth et al., 1986; Murray, 1992) and behavioural difficulties such as problems with sleeping, eating, tantrums and separations (Murray, 1992).

In terms of later cognitive development, Hay et al. (2001) found that the 11-year-old children of women who were depressed three-months postpartum had significantly lower IQ scores, with boys more severely affected. These children were also more likely to have difficulties with attention and to have special educational needs. In reviewing mediating factors between postnatal depression and adverse child outcomes Murray and Cooper (1997) stress early maternal interactional style, secondary to exposure to depression/social adversity, as critical in contributing to adverse outcomes.

In a prospective longitudinal study, Halligan et al. (2007) report the impact of postnatal depression, and later depression, on emotional well-being in 13-year-old adolescents. It was found that adolescents exposed to maternal post-natal depression showed elevated rates of affective distress. Mothers who experienced postnatal depression were significantly more likely to experience further depression (83 per cent did) relative to mothers without postnatal depression. The presence of postnatal depression was only associated with depression in the 13-year-olds where there had also been subsequent maternal depression. In contrast, 13-year-olds exposed to postnatal depression experienced greater anxiety, regardless of re-occurrence of maternal depression. Clearly a wide range of infant, parent and environmental factors influence outcome, however, overall disruptions to early mother-infant interactions, associated with maternal depression, increases risk to the infant's later emotional, social, behavioural and cognitive development. Many of these social and environmental factors are not amenable to psychological intervention within a health setting, but it is arguable that the impact on the infant is through the baby's proximal experience of mother-child interaction (Murray et al., 1993) and if that can be ameliorated then the effects on the child will be minimised.

While highly physically vulnerable at birth, the infant is born with developed capacities to respond socially to certain visual, olfactory and auditory stimuli and development within these brain regions occurs over the early months and years. It is thought that the sensitive window for emotional sensitivity and empathy may also lie within the first 18 months of life (Shore, 1997). This development is largely shaped in relationship, within interaction with caregivers. Early interventions to support mothers and infants facing the obstacles to relating that may emerge with postnatal depression would thus seem vital. In the report *Breakthrough Britain: The Next Generation* (Social Justice Policy Group, 2008),

the Centre for Social Justice Commission highlight that until recently policies have typically focused on dealing with the consequences of early adversity, when arguably difficulties are full blown, harder and more costly to address. It is noted that support for families to improve early relationships is arguably the most effective focus for prevention and that 'infancy is both a critical window of vulnerability and also a critical window of opportunity'.

A variety of interventions including non-directive Counselling, Cognitive Behaviour Therapy, Psychodynamic Psychotherapy and medication have demonstrated benefits in terms of accelerating improvement in mother's mood (Cooper et al., 2003; Appleby et al., 1997). However, relatively few studies have examined the impact of therapy for infant outcomes and the mother-infant interaction. Given the importance of the quality of mother-infant interaction to later development, this represents an important gap.

In a randomised-controlled-trial, Cooper et al. (2003) and Murray et al. (2003) demonstrated that despite benefits in maternal mood, psychological interventions targeting only mothers with postnatal depression produced few positive effects for infants at short and five-year follow-up. Recent reviews (Poobalan et al., 2007; Nylén et al., 2006) emphasise that interventions, which target the mother-infant relationship, had the best chance of improving outcomes for the children of depressed mothers, as well as reducing maternal depression. Within Poobalan et al.'s (2007) review, of five randomised-controlled studies that included assessment of mother-child relationship, all five demonstrated some improvements in mother-child relationship irrespective of the type of intervention (e.g. O'Hara et al., 2000; Horowitz et al., 2001; Hart et al., 1998). For example, Glover et al. (2002) and Onozawa et al. (2001) demonstrated significant improvement on every observed dimension of mother-infant interaction, and improved maternal mood, among mothers attending an infant massage class.

It is increasingly evident from the literature that there is a need for interventions to target both the mother's needs and attend to the mother-infant interaction. Addressing maternal depression alone is insufficient for the infant. In the studies above, where interventions have directly targeted mother-infant interactions, there has been a greater improvement. Earlier studies involving cognitive-behavioural strategies (McDonough, 1993); mother-baby psychotherapy (Cramer et al., 1990) and teaching infant cues/massage (Field et al., 1996b) where the quality of mother-infant interaction was targeted, have also shown benefit (Onozawa et al., 2001). The Mellow Babies programme was developed in response to this literature and stems from a modification of Mellow Parenting (Puckering et al., 1994, 2004, 2006), which was previously developed for families with a pre-school child with whom there were relationship problems.

The Mellow Babies programme incorporates more work focused on maternal depression using cognitive behavioural models. Mellow Babies is a group day programme, run one day a week over 14 weeks. The focus is to: (a) explicitly enhance close mother-infant attunement, using a combination of baby-massage, interaction coaching and infant focussed speech (Puckering, 2004, 2005); and (b) offer mothers support for their own distress. Early pilots of the Mellow Babies approach were well attended and the outcomes were positive: mother's depressed mood reduced significantly and video ratings of mother-infant interactions showed significant increase in positive interaction and reduction in negative interaction.

The current study was developed within the Scottish Government's National Programme for Improving Mental Health and Well-Being research initiatives (2005–2006). A waiting list controlled trial of the Mellow Babies intervention was undertaken, aiming to improve outcomes for the infants of mothers with postnatal depression. The objectives were to measure change in

maternal depression and the quality of interaction between mothers and babies.

Method

Design/Ethics

The research was designed as a randomised waiting list controlled trial with before and after measures of maternal mood and mother-infant interaction. Ethical approval was given by Lanarkshire Local Research Ethics Committee.

Participants

Recruitment took place within the geographical area covered by the local Investing in Infants Programme within North Lanarkshire. Within this area, health visitors routinely screen all new mothers, at six weeks, using the Edinburgh Postnatal Depression Scale (Cox et al., 1994). Mothers scoring >10 (consistent with possible postnatal depression) are offered non-directive counselling listening visits by health visitors, and then re-screened around 12 to 16 weeks. For those mothers scoring above the clinical threshold at 12 to 16 weeks, health visitors were asked to explain the nature of the trial of Mellow Babies and offer referral to the programme. Where mothers agreed, informed consent was obtained and they were randomised, by the toss of a coin, to immediate intervention or waiting list control. Waiting list participants had subsequent opportunity to participate in a group.

Only mothers who were experiencing florid psychosis or whose drug use was uncontrolled were excluded, as it was considered that they were unlikely to be able to participate in the group. Liaison with social work and child protection agencies was intrinsic to the programme and carefully maintained. All other supports (e.g. referral to adult psychiatry, medication) were offered to the women as usual, according to the local Integrated Care Pathway for the management of postnatal depression.

The hope was to recruit 24 mothers (12 in each group). There was a lower rate of referral than expected and ultimately:

- Eleven mothers completed a group.
 - One mother dropped out of treatment and did not wish follow-up.
 - Six mothers completed a waiting list period.
 - Two mothers from the waiting list could not be followed up (e.g. moved away, returned to work).
- Average attendance at group sessions was 83 per cent.

Procedures

Mothers were seen at home by the group facilitators prior to the beginning of the group or waiting list period, and again at the end of the group or after a comparable time for the waiting list group. At visits the Edinburgh Postnatal Depression Scale were completed and videotapes were taken during the baby's mealtime, at a time that suited them. Videos varied in length, depending on the time taken to feed the baby, and were on average 15 minutes.

Mellow Babies Group

Mothers and infants attended the group from 10 a.m. to 3 p.m., once a week for 14 weeks. Taxis were provided to facilitate transport to and from the group, lunch was provided and crèche facilities were required.

While babies were cared for in the crèche, the morning psychotherapeutic group provided mothers opportunity to reflect on their own lives, draw links between past and present feelings and relationships, and consider ways of managing depression using broadly cognitive behavioural approaches. Most women had suffered very adverse childhoods and a safe and non-judgemental atmosphere of the group was fundamental. In a previous Mellow Parenting group, anonymous feedback had indicated 'being listened to' and 'not being judged' as crucial factors that made the most difference to mothers (Puckering, 2004).

Mothers, children and staff took lunch together and this was followed by play-time, where interaction coaching, baby massage, looking at picture books, lap games and

nursery rhymes were all used as a means of promoting close and attentive interaction and attunement.

While the babies were again in the crèche, the afternoon parenting workshop used the mothers' own videos of interacting with their baby during the feed. Examples of incidents that went well and those that did not turn out the way they would have wished were discussed. Facilitators had been through the videos with mothers previously at home in preparation for this activity. From previous Mellow Parenting groups we had learned that mothers could be reticent about being in the spotlight but enjoyed and learned from seeing how others coped. The group was structured but not directive and facilitators avoided suggesting solutions but supported sharing by other group members. In previous groups, mothers had found being the provider of a solution for another mother very empowering. Mothers had also been found to be readily able to identify their failings but had found it very hard to give themselves credit for what they were doing well. An important part of the facilitators' role was in drawing attention to mother's success and skill (Puckering, 2004). Previously the video workshop had enabled mothers to develop empathy with their child in wondering, 'how it feels for him/her?'

Mothers were given encouragement to try tasks out between sessions. Fathers were invited to three evening sessions, information on postnatal depression was discussed and activities to promote father-baby interaction introduced. In the final session of each group, participants were asked to give their anonymous views of the group in a self-completion questionnaire. The group was delivered by a counselling psychologist and health visitor, with monthly supervision from the programme author. The combination of a psychologist with an understanding of adult psychological processes and harnessing these for change, and an expert on early development provided a sound basis

to think about the welfare of the children as well as the well-being of the mothers.

Assessments¹

Changes in maternal mood were assessed using the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1994). Video-taped interaction between mothers and babies was analysed according to the Mellow Parenting observation coding scheme. The scheme is reliable, sensitive to change and shows concurrent validity with other measures of family functioning (Puckering et al., 2006; Robertson, 2006). Coding was carried out by two graduate psychologists, trained to research reliability criteria (>80 per cent reliability), who were blind to group status. There are six positive and six negative dimensions scored under the coding scheme. The dimensions, each with a positive and negative pole, are: (1) anticipation of the child's need; (2) responsiveness; (3) autonomy; (4) co-operation; (5) distress; and (6) control and conflict (see Table 1). The dimensions were summed to give a total positive and total negative interaction score for each mother.

Statistical analysis

Changes in the EPDS and observation measures were analysed using non-parametric statistics (Mann-Whitney U test), as the sample sizes were small, the groups not completely independent and distribution of scores not normally distributed.

Results

Maternal Mood:

Edinburgh Postnatal Depression Scale

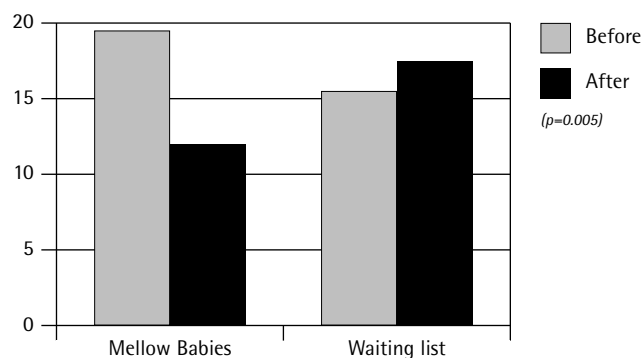
Figure 1 illustrates the changes in EPDS scores. Before the group, mothers in the intervention group had a mean score of 18.8 ($SD=4.7$), while the mean score for those in the control group was 15.7 ($SD=7.1$). By the end of the four-month follow-up period there was no significant change in mood among mothers in the control group

¹ For details of additional post-hoc assessment of observations and health visitor interviews see Puckering, Hickey and Longford (2005–2006), Mellow Babies, www.mellowparenting.org

Table 1: Brief description of observation coding dimensions.

<i>Dimension</i>	<i>Description (example)</i>
Anticipation of child's need	Is the child given advanced preparation for a change in activity? (positive, e.g. <i>let's change your nappy now – lifts infant</i>)
Responsiveness	Are the parent and child responsive/reciprocal with each other? (positive, e.g. <i>mother and infant looking in mirror, mother smiles 'beautiful baby', baby smiles looking closely</i>)
Autonomy	Does the parent show awareness of the child's individuality? (positive, e.g. <i>Do you want your bottle now? Have you had enough?</i> negative, e.g. <i>child fusses, parent continues dressing regardless</i>)
Co-operation	Do parent and child co-operate/negotiate together? (positive, e.g. <i>infant reaches for a pen, mother lifts it away and offers rattle, infant takes rattle</i>)
Distress	Is comfort/support offered to a crying child who is upset or hurt? (positive, e.g. <i>noise startles infant who cries, mother cradles child 'did you get a fright?'</i> negative, e.g. <i>child cries, mother says 'Shut up'</i>)
Conflict and Control	Does parent intervene appropriately to achieve legitimate compliance?

Figure 1: Edinburgh Postnatal Depression Scale in Mellow Babies group and Waiting list controls.



(mean score=17.4, $SD=8.0$). Mood in mothers attending the group had improved, with the mean score falling to 11.9 ($SD=5.6$). The difference in EPDS scores between mothers in the intervention and control groups following intervention was statistically significant ($p=0.005$, Mann Whitney).

Observed Mother-Infant Interactions

Total scores from mother-infant observed interactions were compared. The difference in positive interaction between the intervention and waiting list control group following intervention was statistically significant ($p=0.015$). Thus greater positive interaction was observed between mothers and infants who had attended the group (see Figure 2).

The differences in negative interaction, between the intervention and waiting list control group approached statistical significance ($p=0.07$). Thus less negative interaction was observed between mothers and infants who had attended the group (see Figure 3).

Table 2 shows full analysis of the observations scores, for each dimension, from mother-infant interactions. The table shows that after group intervention or wait, significant differences were found for positive anticipation ($p=0.02$), positive responsiveness ($p=0.018$), negative autonomy ($p=0.019$) and negative control ($p=0.007$). These changes occurred in the expected direction, thus these positive dimensions were higher and negative dimensions lower among the intervention group.

Figure 2: All observed positive interaction in Mellow Babies group and Waiting list controls.

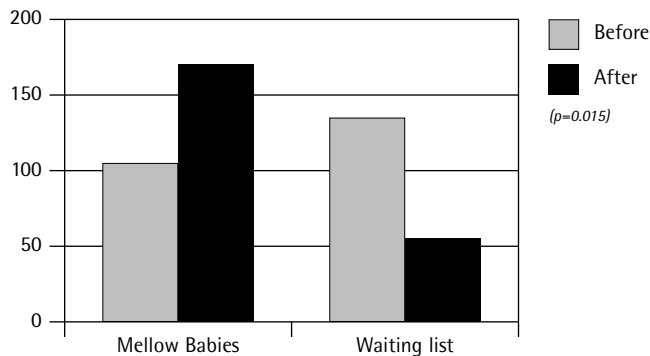


Figure 3: All observed negative interaction in Mellow Babies group and Waiting list controls.

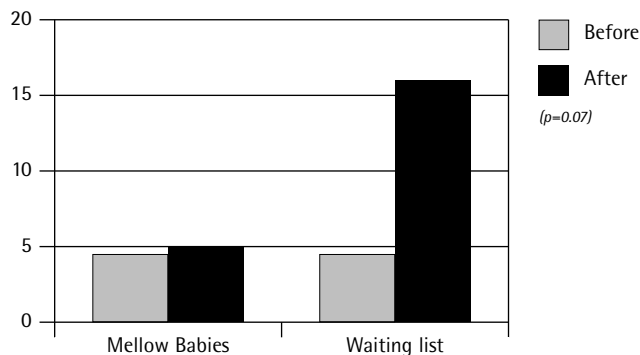


Table 2: Observation measures for Mellow Babies and Waiting list controls: means and (standard deviations).

	Mellow Babies		Waiting list control		Difference between intervention and waiting list group after intervention/wait (Mann-Whitney)
	<i>Before</i>	<i>After</i>	<i>Before</i>	<i>After</i>	
Positive Anticipation	11.7 (8.3)	22.1 (19.8)	17.4 (10.1)	8.8 (5.7)	$z=-2.042$ $p=0.020$
Positive Autonomy	28.7 (28.8)	41.4 (19.5)	32.8 (25.2)	17.8 (5.5)	$z=-1.417$ $p=0.090$
Positive Responsiveness	61.1 (36.7)	93.7 (36.0)	63.0 (14.4)	30.4 (20.4)	$z=-2.097$ $p=0.018$
Positive Co-operation	2.7 (3.1)	5.8 (10.5)	19.8 (39.4)	2.2 (3.4)	$z=-1.536$ $p=0.062$
Positive Distress	0.5 (0.9)	5.8 (10.8)	0.20 (4.5)	1.2 (1.3)	$z=-0.117$ $p=0.456$
Positive Control	0.3 (0.6)	0.1 (0.3)	0. (0)	0.4 (0.9)	$z=1-1.116$ $p=0.081$
Negative Anticipation	0.2 (0.4)	0.6 (1.2)	1.0 (1.7)	0 (0)	$z=-1.308$ $p=0.205$
Negative Autonomy	2.55 (4.8)	2.1 (3.0)	2.0 (3.5)	7.8 (6.5)	$z=-2.078$ $p=0.019$
Negative Responsiveness	1.4 (2.4)	2.2 (4.8)	0.8 (0.8)	3.6 (7.0)	$z=-0.474$ $p=0.871$
Negative Co-operation	0.09 (0.3)	0.2 (0.6)	0.2 (0.4)	1.8 (2.5)	$z=-1.304$ $p=0.182$
Negative Distress	0.09 (0.3)	0.09 (0.3)	0 (0)	1.6 (3.1)	$z=-1.565$ $p=0.059$
Negative Control	0.2 (0.6)	0 (0)	0.3 (0.8)	1.6 (2.6)	$z=-1.043$ $p=0.007$

Participant feedback

At the final session anonymous feedback was provided using self-completion questionnaires ($N=11$). The responses were strikingly positive with no adverse feedback given. Mothers indicated that the most important things they had learnt were around how to look after themselves and enjoy their relationships with their babies; understanding more about their experiences and depression; that other mothers were going through the same thing.

- *'I got a lot out of the group; it gave me insight into how I was feeling and how to cope.'*
- *'How to deal with things reasonably and how to get the most out of my relationship with my child.'*
- *'Understanding what can cause depression. Knowing that there are others in the same boat.'*

The women particularly enjoyed meeting other mums and developing a bond with them and valued the opportunity for their child to mix with other children. Suggestions

for improving groups included a longer programme; more practical advice; and discussion about the causes of depression earlier in initial group sessions.

When asked Have you got what you wanted? mothers' responses were 'yes' 60 per cent and 'partly' 40 per cent. Eighty per cent of mothers indicated that they had changed their behaviour, with 20 per cent changing 'in some ways'.

When asked Have your children changed? 50 per cent of mothers noted, 'yes', 25 per cent noted 'partly' and 25 per cent 'not sure'.

- *'I've stopped letting things I cannot control affect me.'*
- *'I spend more time with my child.'*

No specific feedback was requested from fathers but the very high attendance at three parallel partners' sessions in the evenings was a testament both to their thirst for information and the value they placed on the group.

Discussion

This waiting list controlled trial has shown benefits for mothers experiencing postnatal depression and their infants from attending the 14-week Mellow Babies intervention. Participant mothers reported improved mood with Edinburgh Postnatal Depression Scores falling significantly. Maternal mood for mothers in the waiting list control did not show significant change and the difference in mood scores between both groups at follow-up was statistically significant.

Video assessments, using the Mellow Parenting Coding system, found that observed positive mother-infant interactions increased significantly following the intervention group as compared with the control group. Conversely, relative to the control group, the lower levels of total observed negative interaction approached a significant level in the intervention group. At follow-up, two positive dimensions (anticipation and responsiveness) were significantly

higher among the intervention group and two negative dimensions (negative autonomy and negative control) significantly lower. Overall 10 out of 12 dimensions changed in a direction that favoured those who took part in the group. Feedback on the content and process of Mellow Babies, from mothers who completed the group, was highly positive.

The main limitations of the study were the small sample size and retention within the waiting list group. It had been hoped to recruit two groups of 12 mothers, however, ultimately fewer referrals to the programme were made. Health visitors, who organised initial screening and referrals, indicated that reasons given by mothers who did not wish to join the study included reluctance to join a group, fears of what may come out and concerns about being video-taped, not uncommon responses (Puckering et al., 2005–2006)². It may be that with additional time, continued careful preparation and engagement could allay fears and enable more mothers to accept referrals in the future. Two mothers within the waiting list group were lost to follow-up due to change in circumstances (e.g. moving/seeking other help). It may be that the period of rapid development within the baby's first year, demands rapid adjustments for families that are inconsistent with 'waiting'. Infant development is so urgent and so active at this period, not intervening is not an ethical option when, as this study reinforces, not intervening leads to a deterioration in families where distress has already been identified. Despite limitations significant findings emerged from the small sample of participating mothers, suggestive of substantial effect sizes that carry clinical as well as statistical weight.

The collective evidence, from previous studies, clearly underlines the potential short and longer-term adverse effects of postnatal depression for the infant's relationships, social/emotional, language/cognitive

² For details of Health Visitor Interviews see Puckering et al. (2005–2006), Mellow Babies, www.mellowparenting.org

and behavioural development (Field et al., 1990; Stein, 1991; Murray, 1992; Murray & Cooper, 1997; Halligan et al., 2007). Wider vulnerability factors (e.g. infant gender, socioeconomic resources, chronicity/timing of depression) have been associated with outcomes and it appears that, alongside these factors, the quality of the mother-infant interaction and relationship particularly contributes, at least in part, to outcome (Murray & Cooper, 1997, 2003; Poobalan et al., 2007). Recent reviews (Poobalan et al., 2007; Nylén et al., 2006) highlight both that interventions targeting maternal depression are insufficient for infant outcomes (Cooper et al., 2003; Murray et al., 2003) and that approaches directly addressing the mother-infant relationship showed the best chance in improving outcomes for both mothers and infants (Horowitz et al., 2001; Hart et al., 2002; Onozawa et al., 2001; Cicchetti et al., 2000).

The Mellow Babies approach, adopted in this study, focuses both on providing support to vulnerable mothers to alleviate depression and explicitly addressing mother-infant interaction and relationship. The group draws on approaches such as interactive coaching; baby massage; infant focused speech; cognitive behavioural strategies previously shown to benefit both the interaction and mothers' mental state (Glover et al., 2002; Field et al., 1996; Murray et al., 1993; Appleby et al., 1997; McDonnough, 1993). Positive change in maternal mood and observed infant interaction (e.g. increased maternal sensitivity in anticipation and responsiveness) suggests that the dual aims of addressing maternal mental state and the interaction were both met. The findings are also consistent with previous evidence that direct support with parenting may be needed to make an impact on key aspects of the mother child interaction (Puckering, 2004; Murray et al., 2003).

Importantly, feedback would indicate that the group's format is one that parents like. Attendance was good (83 per cent of sessions) and mothers remained largely

engaged in what is an intensive 14-week programme. One mother noted that being in the group felt '*Good, I felt included, comfortable, able to talk or stay quiet without any pressure.*' Active care was taken, in facilitation, to provide an experience of nurture and acceptance for mothers – beginning to meet some of their needs that so often get overlooked when caught up with caring for a new infant and wider stress. Thus providing the basics: a safe environment, transport, lunch and, of course, respect/valuing/empathy, were important containing components. In turn mothers became more equipped to provide this care for their infants.

An opportunity for children to mix with other children and for mothers to form a bond with others at the group was highlighted as a key component for participants. Provision of an environment that enables mothers to sample supportive relationships, has been a key component of both Mellow Parenting and Mellow Babies. Traditionally, due to a history of social and interpersonal challenges, those most at risk of postnatal depression and mental health/relationship distress are those least likely to engage with routine parenting supports (Puckering, 2004). Whilst initially engaging mothers in a group environment may require careful preparation, the power of the group includes reducing isolation and the direct message/experience of 'not being alone', clearly a component valued by the mothers in the group.

The Centre for Social Justice Commission (Social Justice Policy Group, 2008) has recently underlined the need for effective, timely supports for families to be made available at antenatal, postnatal and infant stages. Too often babies and young children, society's most vulnerable members, have been overlooked by support services and in policy. The Mellow Babies intervention is one approach that aims to prioritise infant mental health while concurrently offering support for mothers experiencing postnatal depression and their families. The evidence would suggest that investing support for

mother-infant relationships is a key element in protecting against later distress (Shore, 1997; Murray & Cooper, 1997).

The study has shown substantial benefit among those attending the group and provides a strong basis for a larger study. Following the rigour of studies such as Murray et al. (2003), it would be helpful to include long-term follow-up and assessment of the direct effects on infant development, seen to be compromised in the context of maternal depression.

The authors

Christine Puckering

Research Fellow,
Caledonia House,
Royal Hospital for Sick Children,
NHS Greater Glasgow.

Emily McIntosh

Clinical Psychologist,
Department of Clinical &
Counselling Psychology,
Monklands Hospital,
NHS Lanarkshire.

Anne Hickey

Counselling Psychologist,
Department of Clinical &
Counselling Psychology,
Monklands Hospital,
NHS Lanarkshire.

Janice Longford

Associate Director of Nursing,
Strathclyde Hospital,
Motherwell.

Correspondence

Christine Puckering

Research Fellow,
Caledonia House,
Royal Hospital for Sick Children,
NHS Greater Glasgow,
Glasgow G3 8SJ.
E-mail: c.puckering@clinmed.gla.ac.uk

References

- Appleby, L., Warner, R., Whitton, A. & Farragher, B. (1997). A controlled study of fluoxetine and cognitive behavioural therapy in the treatment of postnatal depression. *British Medical Journal*, *31*(314), 932–936.
- Cichetti, D., Rogosch, F.A. & Toth, S.L. (2000). The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring of depressed mothers. *Journal of Abnormal Child Psychology*, *28*, 135–148.
- Cohn, J.F. & Tronick, E.Z. (1983). Three-month-old infants' reaction to simulated maternal depression. *Child Development*, *54*, 185–193.
- Cooper, P.J., Murray, L., Wilson, A. & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of postpartum depression: 1. Impact on maternal mood. *The British Journal of Psychiatry*, *182*, 412–419.
- Cox, J. & Holden, J. (1994). *Perinatal psychiatry: Uses and abuses of the Edinburgh Postnatal Depression Scale*. London: Gaskell.
- Cramer, B., Robert-Tissot, C., Stern, D. et al (1990). Outcome evaluation in brief mother-infant psychotherapy: A preliminary report. *Infant Mental Health Journal*, *11*, 278–300.
- Field, T., Grizzle, N., Scafidi, F. et al. (1996b). Massage therapy for infants of depressed mothers. *Infant Behaviour Development*, *19*, 107–112.
- Field, T., Healy, B., Goldstein, S. & Guthertz, M. (1990). Behaviour-state matching and synchrony in mother-infant interactions in non-depressed versus depressed dyads. *Developmental Psychology*, *26*, 7–14.
- Field, T., Healy, B., Goldstein, S., Perry, S., Bendell, D., Schanberg, S., Zimmerman, E.A. & Kuhn, C. (1988). Infants of depressed mothers shown 'depressed' behaviour even when with non-depressed adults. *Child Development*, *59*, 1569–1579.
- Glover, V., Onozawa, K. & Hodgkinson, A. (2002). Benefits of infant massage for mothers with postnatal depression. *Seminars in Neonatology*, *7*, 495–500.
- Halligan, S.L., Murray, L., Martins, C. & Cooper, P.J. (2007). Maternal depression and psychiatric outcomes in adolescent offspring: A 13-year longitudinal study. *Journal of Affective Disorders*, *97*, 145–154.
- Hart, S., Field, T. & Nearing, G. (1998). Depressed mothers' neonates improve following the MABI and a Brazelton demonstration. *Journal of Pediatric Psychology*, *23*, 351–356.
- Hay, D.F., Pawlby, S., Sharp, D., Asten, P., Mills, A. & Kumar, R. (2001). Intellectual problems shown by 11-year-old children whose mothers had postnatal depression. *Journal of Child Psychology and Psychiatry*, *42*(7), 871–889.
- Horowitz, J.A., Bell, M., Trybulski, J. et al. (2001). Prompting responsiveness between mothers with depressive symptoms and their infants. *Journal of Nursing Scholarship*, *33*, 323–329.
- Lyons-Ruth, K., Zoll, D., Connell, D. & Grunebaum, H.U. (1986). The depressed mother and her 1-year-old infant: Environment, interaction, attachment and infant development. In E.Z. Tronick & T. Field (Eds.), *Maternal depression and infant disturbance. New directions for child development* (Vol. 34, pp.61–82). San Francisco: Jossey Bass.
- McDonnough, S.C. (1993). Interaction guidance: Understanding and treating early infant-caregiver relationship disturbances. In C.H. Jr. Zeanah (Ed.), *Handbook of infant mental health* (pp.414–426). New York: Guilford Press.
- Murray, L. (1992). The impact of postnatal depression on infant development. *Journal of Child Psychology and Psychiatry*, *33*, 543–561.
- Murray, L. & Cooper, P.J. (2003). The impact of postpartum depression on child development. In I. Goodyer (Ed.), *Aetiological mechanisms in developmental psychopathology*. Oxford: Oxford University Press.
- Murray, L. & Cooper, P.J. (1997). Postpartum depression and child development. *Psychological Medicine*, *27*(2), 253–260.
- Murray, L., Cooper, P.J., Wilson, A. & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of postpartum depression: 2. Impact on the mother-child relationship and child outcome. *The British Journal of Psychiatry*, *182*, 420–427.
- Murray, L., Fiori-Cowley, A., Hooper, R. et al. (1996). The impact of postnatal depression on infant development and associated adversity on early mother-infant interactions and later infant outcome. *Child Development*, *67*, 2512–2526.
- Murray, L., Kempton, C., Woolgar, M. & Hooper, R. (1993). Depressed mothers' speech to their infants and its relation to infant gender and cognitive development. *Journal of Child Psychology and Psychiatry*, *34*(7), 1083–1101.
- National Institute for Health and Clinical Excellence (2007). *CG45 Antenatal and postnatal mental health*. Retrieved from: <http://guidance.nice.org.uk/CG45>

- Nylen, K.J., Moran, T.E., Franklin, C.L. & O'Hara, M.W. (2006). Maternal depression: A review of relevant treatment approaches for mothers and infants. *Infant Mental Health Journal*, 27(4), 327–343.
- O'Hara, M.W., Stuart, S., Gorman, L.L. et al. (2000). Efficacy of interpersonal psychotherapy for postpartum depression. *Archives of General Psychiatry*, 57, 1039–1045.
- Onozawa, K., Glover, V., Adams, D., Modi, N. & Kumar, C. (2001). Infant massage improves mother-infant interaction for mothers with postnatal depression. *Journal of Affective Disorders*, 63, 201–207.
- Poobalan, A.S., Aucott, L.S., Ross, L., Smith, W.C.S., Helm, P.J. & Williams, J.H.G. (2007). Effects of treating postnatal depression on mother-infant interaction and child development. *The British Journal of Psychiatry*, 191, 378–386.
- Puckering, C. (2004). Mellow Parenting, an intensive intervention to change relationships. *Signal (Bulletin of the World Association for Infant Mental Health)*, 12, 1–5.
- Puckering, C. (2005). Mind the gap – helping the children of mothers with postnatal depression, *Editorial. Child: Care, Health and Development*, 35(1), 7–9.
- Puckering, C., Cox, A., Mills, M., Rogers, J., Mattsson, M., Maddox, H. & Evans, J. (2006). The impact of intensive family support on mothers and children: Mellow Parenting programme. *In Revision*.
- Puckering, C., Hickey, A. & Longford, J. (2005–2006). *Mellow Babies final report*. Retrieved from: www.mellowparenting.org
- Puckering, C., Mills, M., Rogers, J., Cox, A.D. & Mattsson-Graff, M. (1994). Mellow Mothering: Process and evaluation of a group intervention for mothers with parenting difficulties. *Child Abuse Review*, 3, 299–310.
- Robertson, J. (2006). *Adapting the Mellow Parenting scale to assess videoed meals in children aged 1- to 2-years-old: Is it practical, valid and reliable, and does it discriminate between children with and without weight faltering?* D.Clin Psych Thesis. University of Glasgow.
- Royal College of Midwives Survey (2007). Cited in Social Justice Policy Group (2008), *Breakthrough Britain: The next generation* (Executive Summary, p.3). London: Centre for Social Justice.
- Shore, A.N. (1997). *Rethinking the brain: New insights into early development*. New York: Families and Work Institute.
- Scottish Intercollegiate Guidelines Network (2002). *Guideline 60 Postnatal depression and Puerperal Psychosis*. Retrieved from: www.sign.ac.uk/guidelines/fulltext/60/index.html
- Social Justice Policy Group (2008). *Breakthrough Britain: The Next Generation*. London: Centre for Social Justice.
- Stein, A., Gath, D.H., Bucher, J., Bond, A., Day, A. & Cooper, P.J. (1991). The relationship between postnatal depression and mother-child interaction. *British Journal of Psychiatry*, 158, 46–52.

The right to choose: Existential-phenomenological psychotherapy with primary school-aged children

Fenella Quinn

Research shows that, on average, one in 10 primary school-aged children in the UK have some kind of diagnosable mental health problem (Department of Health, 2004). Various agencies are involved in working with children's emotional well-being, from statutory and voluntary sectors, and it is a growing field. Much of the therapeutic work carried out with young children takes place through the medium of play therapy and is thought about often from psychodynamic/psychoanalytical, behaviourist or systemic theories. This paper seeks to consider the approach of working in an existential-phenomenological way with children and how existential philosophy can inform the child practitioner's thinking and interventions. While existential philosophers point to various ontological factors of life including freedom, isolation, relatedness, meaninglessness, anxiety and death/nothingness, this paper examines two of these strands in relation to working with children. The areas of freedom and personal responsibility are explored, together with relatedness and intersubjectivity. While some arguments against using these ideas with children are raised, the paper seeks to reassure practitioners that an existential-phenomenological approach to working with children is not only an appropriate approach, but can also bring about significant alleviation of children's distress.

LIKE ADULTS, children come to psychotherapeutic situations with a wide array of difficulties with living. These can include interpersonal problems, school refusal, bullying, fear of death, fear of hell and the devil, an inability to concentrate or learn in the classroom, an inability to 'behave well' at home, difficulties around parental disputes and divorce, abandonment and rejection, mutism, drug use in the home, emotional, physical and sexual abuse, homelessness, panic attacks, sibling rivalry and bereavement. The list is as long as the number of children who present themselves or who are presented by parents or teachers for emotional support, or even for 'correction'.

The way professionals work with children therapeutically is constantly up for debate (Fonagy et al., 2002). In the primary school years (5 to 11), the most common form of therapy is some kind of play therapy, using psychodynamic, person-centered, attachment-based, systemic and other theoretical models to think about the play, depending on the practitioner and service provider.

Parenting, behavioural and CBT strategies are also becoming more widely used in children's mental health settings. Working existentially-phenomenologically does not appear often in open discourse around working with children.

To pose a typically existential-phenomenological question, what does it mean, to work existentially with children? Some clarity can be gained from the derivation of the word existential from the Latin word *existere*: to stand out, to emerge, to become. According to Misiak and Sexton (1973), existential-phenomenological work is an investigation of existence as experienced by man as an individual, its fluidity and constant state of 'becoming'. Existential-phenomenology is characterised by its emphasis on key 'givens' of existence: freedom and responsibility, meaninglessness, isolation and ultimately, death and nothingness. In phenomenological thinking, symptoms of mental disturbance are expressions of an individual's attempts to defend against these central existential anxieties.

Working phenomenologically

Clearly there are as many different ways of working existentially as there are practitioners doing so. According to Cohn, Heidegger talked in the Zollikon Seminars about the necessity and difficulty of focusing on the phenomena (2002, p.75). Heidegger's hermeneutical view of phenomenology lends itself very well to working with children, for whom context is everything. The continual reinterpretation of phenomena and the examination of the process of interpretation are necessary parts of working with children, who often communicate through metaphor or other oblique means. Working existentially it would be accepted that it is impossible to arrive at a definite solution or final interpretation of what a child might mean through his work; one can only 'continually reinterpret the phenomena', as Heidegger would have us do.

By carrying out the process of trying to discover meaning, both inside the therapy room with the child and outside in supervision and in private contemplation, the therapist can achieve multi-layered understanding of their child client. But even while arriving at certain realisations, the therapist can bear in mind that there will always be more complexities to what has gone on; they can never truly 'know' the full details.

Conducting play, art or drama therapy with a child in a child-centred way can by its nature become phenomenological, and lends itself to this type of approach. In the main, the work can be entirely at a metaphorical level, and to help and encourage a child to play out or create his concerns in that moment is to give 'priority to the phenomena' (Cohn, 2002). Children will, for example, create images and forms which, taken out of context, may seem meaningless, but within the context of the play room, the course of therapy so far and the relationship between the two people in it, carry huge importance and often very complex meaning. To take a reasonably clear-cut example, many children present with symptoms that point to repressed feel-

ings about younger siblings. In their artwork they may paint images of sadism and destruction that could be interpreted as powerful rage and hatred of the usurping baby, such as babies stuffed down toilets, babies with their heads chopped off, and so on.

In phenomenological work, the emphasis is on the here and now experience of the child and therapist together. It is not a case of doing therapy to the child, or – crucially – having an agenda for the child to change, but more a case of getting alongside the child, letting the child 'be' and of the therapist 'being with' and 'being for' the child. The existential-phenomenological therapist should not be driven by the desire to bring about shifts in the client; but rather to be with that client in such a way that they completely accept the client and thereby help that client truly understand themselves and their world (Spinelli, 2007). The importance of the work is not on the 'why' but more on the what (noema) and the how (noesis) of the child's material. Rather than being technique led, phenomenological work is a set of principles: 'It is not the understanding that follows technique, but the technique that follows understanding' (Misiak & Wilson, 1973).

Freedom and responsibility

From the writings of Kierkegaard and Nietzsche, through 20th century philosophers such as Heidegger and Sartre, existential philosophy has it that we have far more freedom of thought and belief, behaviour and emotions than we think.

Heidegger's seminal work, *Sein und Zeit* (1927) – translated into English as *Being and Time* (1962) – explored the meaning and physical ramifications of 'being there' (Dasein). Heidegger did not reach a final explanation, and indeed no-one else has got there yet: it is a situation with which we universally find ourselves struggling. Like Sartre, with his notion of living in 'good faith' or 'bad faith', Heidegger concentrated heavily on the idea of living authentically and inauthentically. To live authentically is to

embrace the idea that we are free to construct our own world. However, the price we pay for this freedom is the understanding that we are in a sense isolated, and that life has no meaning or purpose dictated by an 'other'; it is an anxious process which will inescapably end in nothingness. But, on the other hand, the reward of facing up to these facts of life, of taking responsibility for ourselves, rather than living for other people and their rules and demands, is the liberation of making what we want of our own lives.

If we are free to live our lives and to construct meanings for the phenomena around us as we choose, then we are responsible for ourselves. Conversely, if we choose to live in a state of denial of the inescapable facts of our lives, we live inauthentically, and become irresponsible for ourselves. According to Sartre, people living in a state of bad faith deny their own freedom, and with it their capacity to fulfill their personal potential. They excuse their denial by blaming their limitations on externally driven factors such as society, class, gender, parents and religion (1943).

Warnock describes the result:

The inauthentic being: '...ignores the reality of his own relation to the world. There is an ambiguity in his dealings with reality. He partly knows what things are, but partly does not, because he is so caught up in the way other people see them, the labels attached to them by the world at large. He cannot straightforwardly form any opinion, and his statements are partly his own, partly those of people in general ... the conversation of the man who is inauthentic is said to be Gerede (prattle) as opposed to Rede (discourse)' (1970, p.57).

While this seems a laudable aim, is it feasible to ask children to consider life in this way? By dint of their age and station in life, children are in the throes of 'becoming' (hopefully) a fully functioning adult human being. To do this requires a process of assimilation and introjection of cultural and social beliefs from their families, peers and the world around them (Benedict, 1934; Mead, 1935;

Cole, 1998). This can be described as a necessary part of development which ensures the child's survival within its social groups. If the child's eyes are opened to a deception during this phase of their life, what would that mean for their continuing development, which necessarily has to occur against the backdrop of the very family members who may be deceiving them? Does this mean children are in a continual state of living inauthentically, having to believe in the beliefs of others?

Furthermore, is it developmentally advisable to encourage the child to wake up to its world and the reality of its existence, when the child is essentially trapped in its situation and has to remain attached to its care givers in order to survive? Van Deurzen points out that not everyone is suitable for existential work. One of her criteria for suitability is that the client must be someone who questions the status quo, rather than wanting to fit in and be 'normal' (1995). Furthermore, like Laing and his work with people suffering with symptoms of schizophrenia and other mental health problems, British existentialists reject the idea of working with the client to help them slot back into society and the status quo, instead preferring to help them find their own unique way of being. This could be quite a difficult criterion for a child, as often a child not only has to fit in with its status quo in order to survive, at various developmental stages also has a pressing need to be 'normal' and 'the same as everyone else'.

However, children are a lot more critically minded than perhaps they are given credit for, and in their work will often make acute observations about their situation. For example, I heard an example of a group interaction that went like this:

Boy 1: I hated that exercise, I hated everything about it, it was crap.

Boy 2 (aged 5): No William, you hate yourself.

Old sayings such as 'out of the mouths of babes' can carry much insight. Children are well-known for their willingness to express

honest thoughts even when not welcomed by the adults around them. I believe from my work with children that they have their own strong moral compass and an innate, if blurred, understanding of their existential situation, which can be tampered with by environmental factors but rarely absolutely crushed.

'Children are not yet fools, but we shall turn them into imbeciles like ourselves, with high IQs if possible.' (Laing, 1967 p.49)

At a societal level, while children may not be universally believed, UK law enshrines the idea that, so long as a child can prove that he knows right from wrong, he can be believed in a court room situation, almost regardless of age. Take, for example, the recent case of Baby Peter's stepfather, who was successfully convicted of rape on the verbal evidence of a 4-year-old girl (*The Guardian*, 1 May [Electronic version] 2009).

While young children have very limited freedom to choose whose ideas they are exposed to, the point of existential ideas of freedom is not that we are free to do whatever we want. On the contrary, it accepts the limitations of our existence, and exercises freedom in the construing of and reaction to the givens of our existence.

'Our freedom does not lie in our ability to control or determine the stimuli or events that impinge upon us....the significance and meaning I give to the stimulus, the interpretation I might make of the event, ultimately the way I experience the stimulus, is a matter of choice.' (Spinelli, 1989, p.111)

It is from this standpoint that a huge difference can be made with children therapeutically. The idea of authenticity and responsibility can be vitally important when working with children, who often have limited reasoning around why they act and feel the way they do, but, crucially, usually at some level I would contend, desperately want to find out and do something about it. Take a 'naughty boy' who essentially is a highly distressed individual who has no other way to cope with his intolerable feelings of confusion, guilt, shame, low self-

esteem and helplessness, than to 'act out'. In other words, disrupt the class, walk out of class, be rude to the teacher, smash things, hit other children, and so on. This child is constantly isolated at school, punished at home and at school and told he is 'bad', thereby consolidating his fears about himself and the cycle continues.

This sort of child will often present himself in therapeutic work with a genuine desire to feel better, cope with his angry feelings and get on better with everyone. He can be helped, in relation with the therapist, to think about his world and his view of himself and others, and what life is really like for him. A phenomenological understanding of his creations and actions in therapy can help this child understand himself and consequentially understand that he has a choice over how he reacts to the stimuli around him. Of course, it is then up to the child what he does about it, but I would say that, where a child has gained this understanding, at whatever level, he is more likely to survive his situation intact.

Conversely, the shy, withdrawn, depressed child who is often in tears and alone in the playground might, through phenomenological exploration, begin to understand himself and start to get in touch with very angry feelings, that might manifest themselves outside the therapy room for the first time, often to the consternation of those around him. Either result is a sign of an evolving towards authentic existing.

In many cases, no matter what work the child does on himself, conditions at home will stay the same and, therefore, he will be in just the same position. However, one of the hardest things about being in therapy can be the understanding that no matter who has done what to the client, it is up to the client and the client alone to take responsibility for their own life – no one else is going to do it. Unfortunately the same goes for many children (excepting where a child discloses a child protection issue and legal requirements around safeguarding the child come into force). Where no work can

take place with the family, as is often the case, it will be then up to the child and the child alone to grasp responsibility for their existence, in the sense of their inner world and the way they view themselves and the world. If such a child is in a state of readiness to undertake therapeutic work, over a course of time in existential-phenomenological work, he can slowly use the complex interaction between himself and the therapist to increase his trust in his own senses, efficacy, agency, identity and esteem. When enough of these elements are in place, the child can and often does understand the world he lives in well enough to ensure his survival as a discrete entity in the world. Subjective reports from children, teachers and parents will often reveal an improvement in whole family dynamics when a child has been in therapy for a period of time.

Relatedness

To work existentially is to accept and embrace the relatedness of client and therapist, that each interpersonal encounter is an intersubjective experience that affects all parties involved. According to existential thought, the self is not an intra-psycho apparatus, but is situated in the relation between the person and the world.

Many practitioners working with children are acutely aware of the importance of reflexivity, of acknowledging felt sensations, emotional responses and reactions to the material as conduits to understanding the child's world. In psychoanalytical terms, unconscious communications such as transference, counter transference, and, very importantly in work with children, projective identification, are key to the work, particularly where the therapy is an almost exclusively non-verbal encounter. While a traditional psychoanalytical thinker might understand a projective identification as 'belonging to the client', existential thinking would claim that the emotion or sensation under discussion was 'in the field' between client and therapist, and in some way belonged to both parties.

Indeed, several psychoanalytical thinkers have moved away from intra-psycho determinism and towards a relational view of human interaction and psychological development and health. For example, Stolorow and Atwood (1994, pp.ix-xii) describe intersubjectivity theory as 'a field theory or systems theory in that it seeks to comprehend psychological phenomena not as products of isolated intrapsychic mechanisms but as forming at the interface of reciprocally interacting worlds of experience.'

Merleau Ponty took up the Heideggerian notion of Dasein but expanded it to encompass more of an idea of Daseins being in the world with each other. He says: 'There are no longer two independent consciousnesses, with their own different teleologies and distinctive destinies, but two mutually enfolding glances ... One's own body can assume segments derived from the body of another, just as the substance of one's own being passes into the other' (1964, p.15). However, while Merleau Ponty seemed to be saying that people are very much fluid entities that exist in the world, he also retained the idea of them being at the same time individuals – incarnated minds. This seems to leave room for the notion that while the human self is largely an interaction with its environment, there is some scope for private, even internal, workings.

Merleau Ponty's ideas about the nature of being with others in the world seem to lend themselves to working with children, who by nature tend to engage with the world in a more material, literal and embodied way than perhaps adults do. Younger children in particular are not yet fully linguistically developed and therefore tend not to be able to distance themselves from their experience through language as well as adults can. In play therapy, for example, the child therapist lives with the paradox that, for the most part, the child will not talk about their experience. But if the therapist attends carefully, the child will bring the therapist into his four 'worlds' of existence (private, public, physical (Binswanger, 1963) and spiritual

(van Deurzen, 2002) through a variety of means: directly, through metaphor and by giving the therapist access to his feelings by way of the intersubjective experience that takes place between them.

Perhaps this is not so far from Klein's conception of how the constant process of projection and introjection back and forth between infant and mother is, under ideal conditions, the process by which the infant's ego builds strength and become whole. Through this constant flow of psychic traffic between mother and baby, the infant learns to cope with and contain persecutory fantasies about self and other and to become integrated and move from the paranoid schizoid position to the depressive position (1997).

For example, a child I worked with several years ago, who was severely emotionally neglected and had suffered life-threatening physical abuse, used to enjoy some quite sadistic play. Several sessions in she became quite frantic in her activity; she got together a variety of paints and mixed them up into a brown slurry, which she proceeded to smear all over a table. Looking at me with some glee, she wrote my name in it. I experienced a variety of emotions, including worthlessness and humiliation, anxiety and annoyance. This child was making visible some profoundly difficult aspects of her life to me, including massive ambivalence and concern about her feelings of hatred for various members of her family and a huge fear of feeling love for and dependence on another person. I suggested that she was feeling pretty cross with me, at which she laughed maniacally. Many months later as we came to the end of our work together, in the penultimate session, she created a beautiful house and as she did so started to sing (for the first time in my presence) the Whitney Houston song *The Greatest Love of All* in a cracked and emotional little voice. As I listened to her sing the lyrics word perfectly ('the greatest love's inside of me') I experienced a mixture of wanting to laugh and cry, such was the profound emotional charge of

the messages she was giving me. It seemed that this child used the space between herself and her therapist, both of whom were deeply committed to the relationship, firstly to mine the depths of her difficulties and finally to communicate that she had found an alternative way to consider herself in the world in which she lived, and, therefore, open up new possibilities for her life.

Intersubjectivity in the therapeutic relationship

'Human beings relate to each other not simply externally, like two billiard balls, but by the relations of the two worlds of experience that come into play when two people meet.' (Laing, 1967, p.53) Anyone who doubts the intersubjectivity of people working together in the therapeutic dyad, or indeed in any intimate connection, could have their doubts removed by working with children. This endeavour is made more fascinating by virtue of the fact one is working right at the time when the child is busy being formed and forming himself in relation to others. The child is still 'soft', his ego boundaries let traffic in and out very easily and his self-hood is at an early stage of formation. With adults, one often finds oneself listening to stories of childhood and past explanations for current distress, percolated through the medium of the adult body. But with the child, later distress is being potentially laid down in the present. While this means a huge duty of care for the therapist working with such a vulnerable person, it also provides a precious opportunity to help that child form himself such that he is more able to constitute his world in a way that is more beneficial to him on an on-going basis.

Most practitioners who work with children will be aware of the power of a long term, secure attachment, the only one of some children's lives. Having experienced a secure and nurturing relationship, the child can hopefully go forth into the world knowing what it feels like and therefore be able to choose similar experiences. Furthermore, the presence of a securely attached, nurturing adult can even help the child –

and indeed some adult clients – go back and re-do some developmental tasks, such as learn to self-soothe (Gerhardt, 2004). Working from an existential stance with the child offers an intrinsically two-way relationship, in which both parties are committed to each other and the therapist is well-aware of the intersubjective possibilities of her presence for the child in that relationship. This is particularly interesting in the case of children who live in family systems such as those described by Laing and Esterson (1964): highly toxic environments where children are given undermining and diminishing messages about themselves, under the guise of love and concern.

Furthermore while they have some idea of what is going on, their perceptions are continually denied. As Laing (1967) puts it: 'It is not enough to destroy one's own and other people's experience. One must overlay this devastation by a false consciousness inured ... to its own falsity.' When children have their feelings, perceptions and thoughts consistently denied by other members of the family, that child will become highly confused. Children know they are being lied to, but cannot necessarily trust their impressions enough to be able to hold this position. According to Laing, one mechanism that child may later use to defend against this state of affairs is a retreat into mental ill health, such as schizophrenia (1960, 1964, 1967).

A further problem, according to Laing, is not with the family imposing rules, but with the way it does not distinguish between actions and being. So, for example, the child assimilates the identity of 'naughty child', then when a naughty act is punished, the punishment is perceived as a threat to the whole self. Working existentially with children labouring under these circumstances can be particularly rewarding, as it offers a chance to help that child get a more secure hold on his perceptions of the world. For the average child receiving psychotherapeutic help, not only are they coping with major difficulties, they will also probably

think it is their fault, either by dint of toxic messages from those in their system, or because they are, in Piagetian terms, at an ego-centric age where they are still at the centre of their universe and therefore everything in it that goes wrong must be somehow their fault.

By taking an approach such as Laing's, one can work very effectively with children by helping them unpick what is going on, what their role is in it and to aid the child in confirming for himself his own sense of what is going on, rather than whatever false explanation he may have been given by often well-intentioned adults.

An example of a child in this situation was a boy who, over two years of work (from aged 8 to 10) moved from addressing the world in a chaotic way, where he did not know what day it was, how long a week was, what his nationality was, what language he spoke, when his birthday was, let alone why he seemed to have the devil inside him, to the point where he could get up, get dressed and get on the bus to school at the correct time, all without his mother even knowing he had left his bedroom. I suspect that what brought about this shift was largely the presence over an extended period of the basic tenets of any humanistic work: a trustworthy, caring and honest other, who accepted all of his material, however outlandish, and who turned up every week at the same time.

In this type of work, it is of particular importance to be highly consistent, predictable and honest, to be a solid presence against whom the child can test out his ideas. This can be extraordinarily powerful for some children who can seem half mad with confusion about themselves. Children will always retain a sense of their own truth, but this sense becomes tenuous under the weight of alternative interpretations given by trusted adults. An existential therapist can help the child use his will in order to navigate the world in a way that affords him a greater sense of agency, efficacy and, perhaps most important of all, hope.

Correspondence

Fenella Quinn

Home:

Tel: 07793 495774

E-mail: fenellaquinn@talktalk.net

Work:

Tel: 07590 356080

E-mail: fenella.quinn@theplace2be.org.uk

References

- Benedict, R. (1934). *Patterns of culture*. Boston, MA: Houghton Mifflin.
- Binswanger, L. (1963). *Being in the world*. New York: Basic Books.
- Cohn, H. (1997). *Existential thought and therapeutic practice*. London: Sage.
- Cohn, H. (2002). *Heidegger and the roots of existential therapy*. London: Karnac.
- Cole, M. (1998). Culture in development. In M. Woodhead, D. Faulkner & K. Littleton (Eds.), *Cultural worlds of early childhood* (pp.11–33). London: Routledge.
- Department of Health (2004). *Survey of the mental health of children and young people in Great Britain*. London: The Stationery Office.
- Fonagy, P., Target, M., Cottrell, D., Phillips, J. & Kurtz, Z. (2002). *What works for whom? A critical review of treatments for children and adolescents*. New York: Guilford Press.
- Gerhardt, S. (2004). *Why love matters*. East Sussex: Routledge.
- Heidegger, M. (1962). *Being and time*. Oxford: Blackwell Publishing. (Date of original publication, 1927.)
- Klein, M. (1997). *Envy and gratitude and other works. 1946–1963*. London: Vintage.
- Laing, R.D. (1960). *The divided self*. London: Penguin Books.
- Laing, R.D. & Esterson, A. (1964). *Sanity madness and the family*. London: Pelican Books.
- Laing, R.D. (1967). *The politics of experience and the bird of paradise*. London: Penguin Books.
- Mead, M. (1935). *Sex and temperament in three primitive societies*. New York: Morrow.
- Merleau-Ponty, M. (1964). *Signs*. Evanston, IL: Northwestern University Press.
- Misiak, H. & Sexton, V.S. (1973). *Phenomenological, existential and humanistic psychologies: An historical survey*. New York: Gruner and Stratton.
- Sartre, J-P. (1943). *Being and nothingness*. Paris: Editions Gallimard.
- Spinelli, E. (1989). *The interpreted world: An introduction to phenomenological analysis*. London: Sage.
- Spinelli, E. (2007). *Practising existential psychotherapy*. London: Sage.
- Stolorow, R.D. & Atwood, G.E. (1996). The intersubjective perspective. In R.D. Stolorow, G.E. Atwood & B. Brandchaft (Eds.) (1994), *The intersubjective perspective* (pp.ix–xii). Northvale, NJ: Jason Aronson.
- The Guardian* (2009). Retrieved from: www.guardian.co.uk/society/2009/may/03/children-abuse-witnesses-nsppc
- van Deurzen-Smith, E. (1995). *Existential therapy*. London: Society for Existential Analysis.
- van Deurzen-Smith, E. (2002). *Existential counselling and psychotherapy practice*. London: Sage.
- Warnock, M. (1970). *Existentialism*. Oxford: Oxford University Press.

Counselling psychology for children? – The questions of training and career paths in an emerging profession

Annie Riha

THROUGH MY counselling psychology training and my clinical placement with the Place2Be, a charity that works inside schools to improve the emotional well-being of children, I have become very interested in the experiences and challenges that qualified counselling psychologists encounter when working with children. As a result I am researching this topic for my doctorate – an area in counselling psychology which is often overlooked in training modules and possibly, therefore, future career paths in the profession.

Counselling psychologists in the UK are predominantly trained to work with adults, but with evidence mounting of a growing number of children with mental health concerns, it seems important that attention should be widened to the younger population. According to the Office for National Statistics (ONS), children up to the age of 20 years represent 25 per cent of the total UK population, approximately 14.8 million children. One in every 10 of this particular group has a clinically recognisable mental disorder, according to the ONS Health Survey (2004). More worryingly ONS report that suicide is the second leading cause of death from this age range. These statistics strongly imply that there are increasing numbers of children who need professional psychological help, and who may not be receiving it. These troubling figures have been recognised in Dunn and Layard's (2009) recently published book based on The Good Childhood Inquiry. The authors argue that there are not enough child and adolescent psychotherapists working in the UK to meet this need and call for a five-year

plan which includes training at least one thousand child psychological therapists. This could be a gap which counselling psychologists could help to bridge.

Counselling and related interventions are aimed at improving the mental health of children, and meta-analytic reviews confirm the effectiveness of 'therapeutic intervention' over 'no intervention' (e.g. Casey & Berman, 1985; Shirk & Russel, 1992; Downey, 2003). Harris and Pattison (2004) carried out a systematic search of the research on counselling young people to find out the effectiveness of different therapies on children and adolescence. They looked at four main groups of therapy: cognitive behavioural therapy; psychodynamic/psychoanalytic, humanistic/interpersonal and creative therapy. Their findings indicating that on the whole, each of the four main modality approaches to counselling is effective for children across the full range of counselling issues. The National Institute for Clinical Excellence (2005) recommend psychological therapies, in particular individual cognitive behavioural therapy (CBT) or family therapy, over medication for children and adolescents suffering from depression. As yet there is no conclusive empirical evidence for the effectiveness of one specific treatment over another (Downey, 2003). Counselling psychologists in the UK are typically trained in three of these key therapy modalities: psychodynamic, humanistic and the cognitive behavioural approach. There, therefore, seems to be at least a *prima facie* case for counselling psychologists' expertise helping to meet the growing need for mental health provision of children.

The ‘relational’ and ‘contextual’ emphases in counselling psychology seem to be especially relevant to a consideration of the wider cultural dimension of children’s well-being, which a recent report has shown to be severely compromised in the UK (CPAG, 2009). Moreover, counselling psychologists’ unique history of working across a variety of contexts and cultures and their appreciation of difference means that they can significantly facilitate in social and community interventions, for example, psychoeducational support groups for children and parents in communities struggling with poverty and deprivation. Also as there is increasing evidence that children whose parents suffer from a mental health problem are at a much higher risk of developing one themselves (e.g. Hammen & Brennan, 2003) counselling psychologists can use their adult expertise to assist in supporting parents.

More than ever before, the stage is set for additional counselling to be provided for children and adolescents, yet still the majority of counselling psychologists choose to enter into adult work (James, 2004). A key question to be posed is why so few counselling psychologists go on to work with children when there seems to be such a need and range of possible opportunities – a question that the existing literature has notably failed to address. There could be a number of reasons for this. First, the bulk of counselling psychology programmes in the UK do not provide compulsory modules on working with children, nor is it a requirement to work in youth or child and family settings on placements. Secondly, on many programmes those that do decide to take on child placements are only allowed to count a certain percentage towards their client hours. It might be that this deters counselling psychologists from working with children. Stoltenberg (2005) argues that focusing more on children will enhance counselling psychology training programmes, and tellingly adds, ‘How can we call ourselves generalist training programmes without

significant attention to understanding and intervening with children and adolescents?’ (p.684).

The issue of generic versus specialist training seems important when discussing this area. The question is whether a generic training course is sufficient to enable a counselling psychology graduate to work with children and adolescents, if it includes an appropriate placement and effective supervision or do counselling psychologists require more specialist training? In other words is a generic counselling psychologist as skilled as a specialist counsellor to work in specialist areas? There are some who strongly believe that specialist training is needed to work with children. Kegerris (2006), for example, argues that working with children and adolescents demands a great deal that cannot be adequately provided in a course primarily geared to working with adults. This crucial area has not been researched previously, and is being investigated in my ongoing doctoral research.

Counselling children is an extremely relevant topic at the moment, not least in view of the very unfavourable international comparisons of Britain’s children’s well-being in several recent reports (CPAG, 2009); and there are certainly many shortcomings of, and lacunae in, the existing research available. In fact there has not been any research on counselling psychologists working with children, which seems to be a serious gap in the literature. It is arguable that both the psychology field in general, and the counselling psychology field in particular, have failed to keep up with the rapidly changing cultural trends around children’s mental health and well-being needs – in terms of both professional development and training issues, and also with regard to research.

The intention of my doctoral research is to outline and to explore the reasons for these deficiencies in the counselling psychology literature, and to fill a gap that seems fundamental for the emerging counselling psychology profession. It is hoped

that the findings will make an important contribution to the literature on the emerging professional identity of counselling psychology as a discipline, and of counselling psychologists as practitioners. It is also expected to further develop our understanding of the role and contribution counselling psychologists play in settings and with a client group with which they are not traditionally associated.

Note: If you have experience of working with children as a counselling psychologist and would be interested in being a participant in this study, you can e-mail me at: annieriha@hotmail.co.uk

References

- Casey, R.J. & Berman, J.S. (1985). The outcome of psychotherapy with children. *Psychological Bulletin*, 98, 388–400.
- Child Poverty Action Group (2009). *Child well-being and child poverty: Where the UK stands in the European table*. Retrieved from: www.cpag.org.uk/info/ChildWellbeingandChildPoverty.pdf.
- Downey, J. (2003). Psychological counselling of children and young people. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp.322–342). London: Sage Publications.
- Dunn, J. & Layard, R. (2009). *A good childhood: Searching for values in a competitive age*. London: Penguin Books.
- Hammen, C. & Brennan, P.A. (2003). Severity, chronicity and timing of maternal depression and risk for adolescent offspring diagnosis in a community sample. *Archives of General Psychiatry*, 60, 253–258.
- Harris, B. & Pattison, S. (2004). *Research on counselling children and young people: A systematic scoping review*. Rugby: British Association for Counselling and Psychotherapy.
- James, P.E. (2004). On the road towards funded training for counselling psychologists. *Counselling Psychology Review*, 19(3), 32–35.
- Kegerris, S. (2006). Working with children and adolescents – is specialist training necessary? *Psychodynamic Practice*, 12(4), 403–418.
- Office for National Statistics (2004). *Mental Health of Children and Young People in Great Britain 1999 ONS Survey*. Retrieved from: www.statistics.gov.uk/Children/downloads/child_pop.pdf.
- Shirk, S. & Russel, R. (1992). A re-evaluation of estimates of child therapy effectiveness. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33, 361–371.
- Stoltenberg, C.D. (2005). Reflections on reflections: Training in counselling psychology. *The Counselling Psychologist*, 33, 683.
- The National Institute for Clinical Excellence. (2005). *Depression in children and young people*. Retrieved from: www.nice.org.uk/nicemedia/pdf/cg028fullguideline.pdf.

The author

Presently, I am doing my counselling psychology training at Roehampton University. As well as Place2Be, I am also on placement with Richmond MIND and the psychotherapy centre at Barnes Hospital. Previously I undertook a clinical research placement in Sydney where I was co-therapist for a cognitive-behavioural group programme for children with various anxiety problems.

Correspondence

Annie Riha

Trainee Counselling Psychologist,
Roehampton University.

E-mail: annieriha@hotmail.co.uk

A trainee's experiences of counselling psychology's contribution to therapeutic work with children and adolescents

Gail Sinitsky

WHEN I embarked upon the Professional Doctorate in Counselling Psychology, I was advised by a colleague that '*counselling psychologists do not work with children*'. It appeared that there existed a myth that working with children was not within the boundaries of the role of a counselling psychologist. Since I am dedicated to working therapeutically with children and adolescents, and am particularly motivated by counselling psychology's philosophies, it is perhaps unsurprising that I have since regularly re-visited this piece of advice, reflecting on whether counselling psychology is in fact congruent with therapeutic work with children and adolescents. Indeed, my experience of working within voluntary organisations dedicated to the provision of therapeutic services for children and families has highlighted to me how counselling psychology does contribute effectively to therapeutic work with children and adolescents. In this short paper, I reflect upon my experiences of working with children and adolescents during training. In doing so, I aim to challenge the myth that appears to be contained in this piece of advice, by demonstrating that working with children and adolescents does fall within the boundaries of the role of a counselling psychologist. In addition, I have highlighted the valuable contribution that counselling psychology offers to therapeutic work with children and adolescents, by focussing on four contributions: its phenomenological underpinnings (BPS, 2008); its use of the life span developmental approach (Sugarman, 2003); its commitment to the development of well-being (Woolfe, 1990); and its valuable role within a multi-disciplinary framework.

Philosophical underpinnings of counselling psychology

Through my experiences, I have seen how valuable the phenomenological underpinnings of counselling psychology are in relation to working with children and adolescents. In practice, these phenomenological philosophies involve:

- an emphasis on clients' subjective values, beliefs and experiences;
- a search for understanding and meaning; and
- the positioning of the therapeutic relationship as central to the therapeutic task (Strawbridge & Woolfe, 2003).

I have seen how these philosophies can aid the therapeutic process with children and adolescents. For example, through my experiences of providing therapy to children and adolescents, I have realised the importance of developing client-focussed and flexible formulations. Thus, whilst using theory to aid our understanding of clients' experiences, it is important to ensure that formulations are not primarily driven by theory but that they predominantly incorporate clients' subjective experiences, meanings and values, and allow for the integration of concepts from different theories when such concepts present themselves in clients' experiences (Johnstone & Dallos, 2006).

In practice, this involves thinking about children and adolescents in the context of their families, education, peers and wider social and cultural environments. Indeed, integral to therapeutic work with children and adolescents is an emphasis on systemic factors. This approach has been particularly important in my work with adolescents of

immigrant families. It will probably come as no surprise that many of these adolescents are often faced with conflicting cultural values and expectations, which can impact upon the developmental task of identity formation. Here, counselling psychology's phenomenological values have been invaluable.

For example, 15-year-old Sara was referred for therapy at a Family and Adolescent Centre as she was experiencing difficulties in forming friendships. Born in Morocco, Sara was Muslim and had moved to London during infancy. Soon into the therapeutic work, Sara expressed that she struggled to make sense of her identity: she did not identify herself as British, nor did she identify herself as Moroccan. It emerged that this struggle was particularly heightened when she was with her peers, as she believed she could not 'fit in' with their culture whilst she maintained her own religious values. An example of this struggle was Sara's determination to maintain her virginity in the face of peer pressure to increase her sexual experiences. A phenomenological approach was fundamental to the work with Sara; it was imperative for me to develop an understanding of the meanings that she ascribed to her culture, religion, and friendships. This helped Sara to make sense of her difficulties and formed the basis for the identity-work that followed.

Therefore, through these experiences, I have seen how the phenomenological philosophies at the heart of counselling psychology are integral to child and adolescent work.

These philosophies are harnessed during our practice by:

- developing collaborative therapeutic relationships in which clients' subjective experiences, values and beliefs are respected and are used to construct formulations;
- providing a space for our clients to make sense of their experiences and create life stories that are helpful and empowering; and

- engaging in reflexive practice whereby we continually ask questions about our role in the therapeutic work and about the usefulness of formulations to our clients.

In doing so, we develop our understanding of the subjective experiences of children and adolescents in the context of their social, cultural, and family environments.

Life span developmental approach

Through my experiences, I have seen how the life span developmental approach – an approach central to counselling psychology – provides a theoretical framework for working effectively with children and adolescents (Downey, 2003). For example, in my work I have drawn upon child development theories to help me ensure that I communicate and work with each individual child differently, according to their cognitive, emotional and social developmental capacities. In addition, my experiences of providing therapy to adults with mental health difficulties have demonstrated to me that working across the life span can provide insight into how children can be therapeutically supported through challenging experiences in a way that would minimise any future difficulties.

This life span approach gives counselling psychologists information about the impact of childhood experiences, events and transitions on adult mental health and about what interventions may be effective in childhood and adolescence. Moreover, it particularly highlights the importance of providing early intervention and developing well-being in children, ideas central to counselling psychology (see the following section). Therefore, by drawing upon the life span developmental approach, counselling psychology is able to valuably contribute to therapeutic work with children and adolescents. Specifically, this approach provides us with valuable insight about the types of interventions that would be useful, and, I believe, highlights our commitment to supporting children throughout their lives.

Emphasis on the development of well-being

Counselling psychology's aim to focus on the development of well-being and the prevention of psychological difficulties (Woolfe, 1990) demonstrates an additional contribution to therapeutic work with children and adolescents. Rather than focussing on pathology, counselling psychology places an emphasis on facilitating well-being through focussing on the individual as whole – including difficulties, strengths, and potential. Accordingly, counselling psychology values a 'developmental rather than a disease perspective on life events' whereby experiences (both positive and negative) are seen as opportunities for growth (Sugarman, 2003, p.318). In my experiences, I have seen how this emphasis is integral to some of the therapeutic work that counselling psychologists do with children and adolescents. For example, I have seen how a primary task of counselling psychologists is to help children and adolescents make sense of life events and construct life stories which are empowering, rather than problem-saturated. In addition, during my training, I have co-facilitated therapeutic groups in primary schools, aimed at helping children to manage various experiences (including peer relationships, transitions and low confidence) in a way that increases positive self-talk and enhances mindfulness, which is demonstrated to promote well-being in children and adolescents (Greco & Hayes, 2008).

Moreover, this emphasis on well-being positions counselling psychology in an integral position within Government initiatives, which focus on providing early intervention, enhancing resilience in children, and improving outcomes (health, educational and economic) for children and their families. These initiatives include, for example, the extended schools programme, in which schools work in partnership with the local authority and other organisations in order to provide children and their families access to a range of services (DfES, 2005).

It is my view that counselling psychology's commitment to promoting well-being, coupled with its use of the life span developmental approach, ensures that it is able to contribute invaluable to the therapeutic input that is integral to these Government initiatives. Counselling psychologists are able, for example, to provide the therapeutic work to children and their families engaging in these schemes. Moreover, counselling psychologists may be well placed to tackle some of the difficulties associated with such initiatives. For example, some families with complex needs may be disengaged from schools and other services and thus 'excluded' from initiatives such as the extended schools programme. Counselling psychologists can apply their skills and knowledge to help these hard-to-reach children and families. In addition, counselling psychologists could offer consultancy, supervision and training to professionals working within the Government initiatives, and create the vital link between community programmes and health services.

Valuable role within a multi-disciplinary framework

Counselling psychologists' abilities to offer psychological input within a multi-agency and multi-disciplinary framework constitutes an additional contribution to therapeutic work with children and adolescents. Integration within and between services and organisations is fundamental to working effectively with children and adolescents (DfES, 2003). This involves communication and coordination between agencies and disciplines, and through my experiences, I have seen how counselling psychology possesses a valuable role within such an integrated approach. For example, during my experiences of providing therapeutic work to children and adolescents within schools, I met with 14-year-old Sam who was at risk of permanent school exclusion due to his 'violent behaviour' towards both pupils and staff. Professionals involved were keen for him to engage in 'anger management work'.

Our sessions provided Sam with a space in which to express his feelings and experiences through drawings, play and even joke-telling and singing. This enabled us to develop a formulation of his school-based difficulties in the context of his experiences at home. Specifically, he regularly witnessed the emotional and physical abuse of his mother by his stepfather. He expressed a sense of losing control during these abusive incidents and we came to understand how his behaviour at school reflected an attempt at regaining this control. Through this understanding, I was able to provide the multi-agency team (education, health, and social services) with a psychological understanding of Sam's 'violent behaviour'. This informed the wider treatment plan, ensuring that we introduced appropriate services and support for the family, including domestic violence interventions and systemic therapy. As a result, Sam's 'violent behaviour' at school reduced and his academic achievements improved.

This example highlights the crucial contribution that counselling psychologists provide within multi-agency and multi-disciplinary frameworks. Specifically, counselling psychologists are able to inform professionals of the psychological aspects of the experiences of children and adolescents. This ensures that they, and their families, receive the most appropriate and effective support. Moreover, counselling psychologists possess a unique role within the professional network, which involves the application of psychological knowledge and theory in a way that reflects a shift from a focus on pathology towards a focus on understanding children and adolescents' subjective experiences and facilitating their well-being. It is, I believe, because of counselling psychology's dual heritage that they are able to fulfil this role effectively. This dual heritage relates to counselling psychology's historical roots within both the behavioural science and phenomenological paradigms (Strawbridge & Woolfe, 2003). As scientists, counselling psychologists are committed to drawing

upon and contributing to the psychological knowledge base, which provides an understanding of child and adult development and facilitates hypothesising about the experiences of children and adolescents. It is counselling psychology's phenomenological underpinnings that encourage a primary emphasis on clients' subjective meanings and experiences. I believe that this combination of philosophies is at the heart of the unique role that counselling psychology has within the professional network.

Overall, the experiences that I have obtained thus far during my training have provided me with an insight into how counselling psychology contributes valuably to therapeutic work with children, adolescents and their families. However, whilst the advice that was offered to me some years ago appears to me to be ungrounded, I have wondered whether it is reflective of a wider discourse that exists about the lack of a role of counselling psychology in child and family work. This discourse seems to seep into the practice-related experiences of trainees. For example, whilst I have gained placements with voluntary organisations specialising in child and family work, I have found it difficult to obtain a placement within an NHS child and adolescent mental health service. I have regularly been informed that there is a primary duty (both financial and structural) to offer placements to clinical psychology trainees. Moreover, the percentage of child-based counselling hours that can be 'counted' is limited within some doctoral programmes. I have subsequently questioned whether the contribution of counselling psychology to child and family work is overlooked or undervalued.

Nonetheless, in my experience, it is apparent that counselling psychologists can, and do, offer a valuable contribution to therapeutic work with children, adolescents and families. As declared almost two decades ago, counselling psychology's 'primary mission is ... to celebrate its product and seek to explore ways in which this can be spread more widely' (Woolfe, 1990, p.532).

Thus, in light of the growing number of Government initiatives aimed at the development of well-being among children and adolescents, perhaps there is a need for the voice of counselling psychology to be heard more clearly. I believe that it is imperative that we demonstrate the values and skills that counselling psychology can offer to the therapeutic work with children, adolescents and families that are integral to these initiatives. This special edition of *Counselling Psychology Review* is in itself a reflection of counselling psychology's dedication to such work. Moreover, research, consultation, and more specialised training are all areas that can further aid this process. I believe that it is our responsibility to continue to reflect upon and challenge the discourses that exist about counselling psychology, so that we can be best placed to support those in need.

References

- British Psychological Society (2008). *Division of Counselling Psychology professional practice guidelines*. Leicester: The British Psychological Society.
- Department for Education and Skills (2003). *Every child matters*. Nottingham: DfES Publications.
- Department for Education and Skills (2005). *Extended schools: Access to opportunities and services for all. A prospectus*. Nottingham: DfES Publications.
- Downey, J. (2003). Psychological counselling of children and young people. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp.322–342). London: Sage.
- Greco, L.A. & Hayes, S.C. (2008). *Acceptance and mindfulness treatments for children and adolescents: A practitioner's guide*. Oakland, CA: New Harbinger Publications.
- Johnstone, L. & Dallos, R. (2006). *Formulation in psychology and psychotherapy. Making sense of people's problems*. East Sussex: Routledge.
- Strawbridge, S. & Woolfe, R. (2003). Counselling psychology in context. In R. Woolfe, W. Dryden, & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp.3–21). London: Sage.
- Sugarman, L. (2003). The life course as a meta-model for counselling psychologists. In R. Woolfe, W. Dryden, & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp.303–321). London: Sage.
- Woolfe, R. (1990). Counselling psychology in Britain: An idea whose time has come. *The Psychologist*, 12, 531–535.

Correspondence:

Gail Sinitsky

Training at:

University of East London,
London E15 4LZ.

E-mail: gailsinitsky@hotmail.com

A day in the life of a CAMHS Service Manager

Wendy Woodhouse

I AM a counselling psychologist working within the NHS who manages a tier 2 and tier 3 Child and Adolescent Mental Health Service (CAMHS) in addition to providing therapeutic input to the clients referred to the service. CAMHS are organised within a four-tier system as introduced in *The Health Advisory Service Report Together We Stand* (1995). In brief, tier 1 services promote mental health and provide general advice and treatment for less severe problems; tier 2 services provide assessment, treatment, consultation and training for more complex mental health problems; tier 3 services are multidisciplinary and provide assessment and treatment for those with more severe, complex and persistent disorders and tier 4 are inpatient units. The service we provide is city-wide and serves a multicultural diverse population. Whilst parts of the city are relatively affluent, 27 per cent of the population are in the top 10 per cent of the most deprived across the country. My role is relatively rare as very few service manager positions in CAMHS are occupied by counselling psychologists despite the fact that the humanistic ethos of counselling psychology, and the skills acquired through the therapeutic training furnish us with essential requisites to provide effective management and cultivate positive team dynamics. My dual role position as manager and clinician includes numerous and diverse challenges which I hope to illuminate in this article in the hope of encouraging other counselling psychologists to consider future employment in CAMHS management.

The team I manage is a large multi-disciplinary team comprising of clinical and counselling psychologists, child and adolescent psychiatrists, specialist nurse practi-

tioners, social workers, occupational therapists, family therapists, mental health practitioners, primary mental health workers and child psychotherapists. In my experience an ethos of trust and respect contributes to safer working practices, thus a principle aim of my management strategy is to foster positive team dynamics characterised by mutual respect and trust between the different disciplines. Such dynamics are particularly important if complex family dynamics are not to be replicated within the team. Similarly to a healthy functioning family, each member of the team is respected for their unique and individual skills, and development potential is firmly recognised, supported by my open door policy. Clinicians call in to debrief following a particularly difficult session, reflect their decision making process, request second opinions on complex or high risk cases, share ideas and offload frustrations. I thus assume they value the open door policy!

It is something of a task to write about a 'typical working day' since one of the things I enjoy about my current role is its sheer diversity from day to day. I hope to reflect one day in all its 'untypical-ness' acknowledging that flux and change and the management of these are the pivotal essence of my working day.

My day begins before I even arrive at my office as I use the drive to work to prepare, reflecting upon and considering the forthcoming diary commitments. I recall the uncompleted and listed tasks from previous days and ponder on how I might create time to carry out the tasks in conjunction with the present day's commitments. I smile at the irony of my planning because anyone working in CAMHS, especially as a clinical

manager, will know that very rarely does a day go as planned!

As I walk in to the department I am met by my Personal Assistant (PA) who informs me that one of my trainees needs to speak to me urgently regarding a clinical concern and a paediatrician needs to speak to me regarding a young person on my caseload who has been admitted to hospital. Furthermore, a family have arrived for their initial screening appointment but the clinician due to meet with the family has telephoned to say he is delayed in motorway traffic and will be very late. Within a split second, my prepared thoughts and plans are mentally reshuffled and reprioritised to encompass the emerging challenges of the day. Whilst my PA contacts the chairperson to pass on my apologies for the Directorate Clinical Governance meeting, I try to determine which clinician may have a space in their diary to meet with the family who have arrived for a screening assessment. Thankfully, apart from my own case that I need to deal with, no other young people have been admitted with self-harm to our local children's ward overnight and the clinician assigned to the paediatric liaison rota agrees to carry out the screening to avoid the family being disappointed. I meet with the concerned trainee to ascertain the problem and only then am I able to turn my attention to speaking to the paediatrician.

We have recently updated our self-harm protocol that closely reflects best practice according to the National Institute for Clinical Excellence Guidelines for Self-Harm (NICE: Clinical Guideline 16, 2004). We also have a well-developed, evidence-based assessment tool based on the CASE approach that is used when undertaking self-harm assessments (Shea, 1998). Reflecting on the paediatrician's description of events regarding the young person I decide that even though I have conducted previous comprehensive assessments to inform my working formulation an immediate risk assessment using the specific evidence-based tool will be required to assess the suicidal ideation and intent.

In view of the client's complex presenting needs and the chaotic family system which appear to have perpetuated her current presentation, I anticipate a multi-agency professionals meeting will be essential to establish roles and responsibilities and ensure the family receives relevant support prior to discharge. This is yet another unforeseen demand to fit into a pre-planned busy day. However, behind every manager needs to be a good PA and my diary is soon reorganised: an audit on our compliance with the National Service Framework for Children, Young People and Maternity Services (2004) planned for completion tomorrow is rescheduled as the deadline for this piece of work is three weeks away so can wait and job descriptions I need to write to begin a recruitment process for two vacancies are assigned to tomorrow's tasks. One of the vacancies is for a 'clinical/counselling psychologist'. I work in a trust where both clinical and counselling psychologists are given equal opportunities. I value this as I am aware how counselling psychologists are being undermined and put in positions as 'counsellors' by many Trusts. I recently heard from a colleague who was told during an informal information seeking conversation with a potential employee that she would not be considered for a clinical psychologist post as she is a counselling psychologist. Further enquiry elicited that this potential employer's view is that counselling psychologists, even those with doctorates, are unable to fulfill the required specification of a clinical psychologist. This led me to consider the perception some may have with the word 'counselling' in our title and if this, therefore, truly reflects our training, role and expertise as psychologists in a clinical setting.

As I drive over to the local hospital I reflect upon the sad story that was the complicated life script of the young person I was to see, a story familiar to me as I had been working with her for a number of months. I thought about my last supervision session where I had considered why this

young person invades so much of my thinking time. My supervisor and I had considered how close in age she is to my own children and how she may be unconsciously trying to latch on to the maternal feelings I exude through my countertransference. Given this young person has in the last year been bereaved of her mother, sensitive handling and recognition of transference and countertransference is important for the therapeutic relationship and must be held in mind during the multi-agency meeting organised to ensure that all involved professionals are working towards keeping this young person safe from harm. After risk assessing the young person, I advised she should remain on the ward until a multi-agency meeting had taken place to develop a safe, shared care pathway. Having contacted my PA with details to organise the meeting for tomorrow, I begin planning the agenda and desired outcome whilst driving back to the office. A priority during this meeting will be for me to acknowledge and remain sensitive to the different perspectives brought to the discussion by partner agencies. Whilst the goal to keep the young person safe is shared by all, there can be tensions as each profession has a different perspective on how to achieve this aim. I sometimes have the uncomfortable sense that partner agency colleagues view us as being rather precious when we are unwilling to share every bit of information we have without a client's permission and when we uphold the integrity of the therapeutic relationship. This perception may have been reinforced by traditional CAMHS lately being referred to as 'specialist CAMHS' (National CAMHS Review, 2008) to differentiate between the wider use of the term 'CAMHS' adopted by partner agencies who locally have long argued that they also do CAMHS work. However the word 'specialist' has certain connotations that have not been embraced favourably. I often get the sense that partner agency professionals think we view ourselves as 'the only expert' with authority and dismissive of the excellent work they do,

which can result in them feeling undermined and devalued.

The differences between agency, agendas and cultures are highlighted more so when attending meetings in my management role. Abbreviated words, phrases and slogans can at times be akin to conversing with someone speaking a different language and can feel alienating. However, asking questions and checking my understanding is a key part of relationship building. This is important, along with my knowledge of the team's capacity, when making commitments on behalf of the team for closer partnership working and agreements. I have no doubt that, if asked, colleagues from other agencies would describe the same experience following their attendance at health dominated meetings.

Despite this, and given the importance of multi agency working both for the good of our clients but also for CAMHS staff seconded to other teams such as the Youth Offending Team, Early Intervention Team for Psychosis, relationship building must, and does, continue. In the same way I work to build a therapeutic relationship, I utilise humanistic skills of listening, enquiry, seek to understand sometimes very difficult positions, try and establish a common language and goal and be respectful whilst also being congruent and genuine. I consider how best to frame 'interventions' in the light of what I am aiming to achieve whilst trying to understand the inter-relationship dynamics and the pressure of unconscious processes. What advantage we have as counselling psychologists to have received in-depth training in different therapeutic models!

On returning to the office my PA informs me my 2.00 p.m. client has cancelled but a group of clinicians who have recently undertaken training in Dialectic Behaviour Therapy (DBT) have booked in to meet with me following a return-to-work interview with one of the administration staff who has been on sick leave. My PA hands me telephone messages that have been put in order of priority and a sandwich she has thoughtfully

purchased for me. One must never underestimate the first basic level of Maslow's hierarchy of needs! Whilst eating I check and answer e-mails ranging from requests to join a transition group to establish more coherent transition pathways between ourselves and adult mental health, reports on our activity for the Trust board meeting, clinicians' requests, invoice approval requests, and return telephone calls to address both clinical and management queries.

With half-an-hour to spare before the booked in return-to-work interview I continue with a report I began yesterday. Because we have a CAMHS psychologist based within the Youth Offending Team I had been asked to write a report in response to a recent published national audit of health provision in youth offending teams (Commission for Healthcare Audit and Inspection and HM Inspectorate of Probation, 2009). One of the frustrations I experience often is the direction to complete unexpected pieces of work within very tight deadlines. As with this report, it becomes a case of utilising every spare moment, which does not allow for continuity, or alternatively make a decision to cancel existing diary commitments to free up a block of time. Freeing time is preferable but not always appropriate if it means disrupting clinical sessions, supervisions or important meetings.

Having abandoned the report to undertake the return-to-work interview, I begin to think about the next meeting which is the DBT group. I know they will be asking me to consider how existing clinics can be restructured to create time for them to develop and run a new DBT clinic. I anticipate a 'headache' but as the meeting begins I find myself attracted to their enthusiasm and passion for the model and their desire to maximise the difference it could make in the lives of young people referred in to their group. It took me back to when I had completed my counselling psychology doctorate and the mixture of feelings I expe-

rienced. I remember an excitement at being qualified and the feeling of being on the threshold of a new beginning and yet the trepidation of realising I had to take the giant leap to become 'the psychologist' without the title of 'assistant' or 'trainee' to hide behind. I remember wondering if there ever comes a time when you become confident that you 'know it'. However, as time has gone by my experiences and reflections have led me to hold on to the belief that the day I think I 'know it' is the day I know the least of all!

One of the strengths of counselling psychology training is that it motivates flexibility in one's thinking and openness to new ideas. This helps to give me a genuine interest in the ideas which team members bring and encourage them to think flexibly within ethical frameworks. I was impressed with the ideas presented by the DBT group and admired them for the way they came with solutions as opposed to problems. I believe my role isn't just about management and leadership. It is important to recognise the wealth of skills and expertise in a team and in doing so support individuals to develop their ideas and initiatives and thus encourage their skills as leaders. Effective management and leadership is a key driver for patient experience as identified in the final report of Lord Darzi's Next Stage Review who argued that all parts of the system need to work together on implementing and shaping change (Department of Health, 2009). We agreed to meet in a few weeks time to allow me time to ponder on their suggestions and how their suggestions could be integrated into the existing team commitments. The enthusiasm of the group was infectious and I made the decision to prioritise and thus validate their enthusiasm and remain with the discussion, over continuing the report I began earlier in the day.

And so my day ends as it started, with more to do than I began with, the report is scheduled for completion tomorrow! This parallels some therapeutic engagements where the end of the session can feel more disordered and chaotic than the beginning.

The capacity to hold on to, reflect and use the experience rather than panic about the 'content' is certainly a skill I'm grateful my training honed! I close the door to my office, the one time in the day when regulations state it must be closed. Being congruent I own that when I have documents to write I do wish I could close the door in my working hours, but counselling psychologists are social animals – we need the buzz created by interaction with fellow human beings. The door will once again be open in the morning.

References

- Commission for Healthcare Audit and Inspection and HM Inspectorate of Probation (2009). *Actions speak louder: A second review of health care in the community for young people who offend*. Retrieved 5 July 2009 from: www.inspectorates.justice.gov.uk/hmiprob
- Department of Health (2009). *Inspiring leaders: Leadership for quality. Crown gateway reference 11164*. Retrieved from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093395
- NHS Health Advisory Service (1995). *Together we stand: The commissioning, role and management of child and adolescent mental health services*. London: HMSO.
- National CAMHS Review (2008). *Children and young people in mind; The final report of the National CAMHS Review*. Retrieved from: www.dcsf.gov.uk/CAMHSreview
- National Institute for Health and Clinical Excellence (2004). *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. Retrieved from: www.nice.org.uk
- National Service Framework for Children and Young People and Maternity Services (2004). *The mental health and psychological well-being of children and young people standard 9*. Department of Health: Crown Copyright.
- Shea, S C. (1998). The chronological assessment of suicide events (CASE): A practical interviewing strategy for the elicitation of suicidal ideation. *Journal of Clinical Psychiatry (supplement 20)* 59, 58–72.

Correspondence

Dr Wendy Woodhouse

BSc (Hons), CPsychol, MCMI
Counselling Psychologist Service Manager,
Wolverhampton Primary Care Trust,
Child and Family Service (CAMHS),
The Gem Centre,
Bentley Bridge Business Park,
Neachells Lane, Wednesfield,
West Midlands WV11 3PG.
Tel: 01902 444021
E-mail:
Wendy.Woodhouse@wolvespct.nhs.uk

DCoP

One-day Themed Conference



The
British
Psychological
Society

APPROACHING TRAUMA

Saturday 17 April 2010

Venue: BPS London, 30 Tabernacle Street, EC2A 4UE

The programme includes:

Keynote speaker: **Professor Simon du Plock**

+ **TWO workshops** by leading experts in trauma related interventions

For more information go to:

www.bps.org.uk/dcop1dayapril

Trainee Counselling Psychologist Annual Prize 2009 –
Third place winner

A critical review of the controversy surrounding eye movement desensitisation and reprocessing

Joanna Nowill

The treatment eye movement, desensitisation and reprocessing (EMDR) continues to court controversy despite its adoption by the National Institute for Health and Clinical Excellence (2005) as a preferred treatment for post-traumatic stress disorder. This article critically reviews the two issues at the heart of the controversy. First, is EMDR effective for unique reasons or is it a disguised treatment such as exposure therapy? Second, is evidence-based practice an appropriate framework within which to assess psychological therapies or are its criteria too narrow and inflexible? The article proposes practice-based evidence as a potential way forward in EMDR research and describes an appropriate model within an EMDR treatment framework.

Keywords: EMDR, exposure therapy, post-traumatic stress disorder, evidence-based practice, practice-based evidence.

THE TREATMENT eye movement, desensitisation and reprocessing (EMDR; Shapiro, 2001) is approximately 21 years old. Yet despite its adoption by the National Institute for Health and Clinical Excellence (NICE, 2005) as a preferred treatment for post-traumatic stress disorder (PTSD), EMDR remains controversial and continues to be the subject of intense and sceptic debate over two main issues. Neither issue concerns whether EMDR is effective, indeed its effectiveness is now generally accepted, certainly for PTSD (Bisson et al., 2007; NICE, 2005; Perkins & Rouanzoin, 2002; Sikes & Sikes, 2003). The first controversial issue questions whether its effectiveness is because EMDR does not actually offer a new treatment but is instead a clever marketing ploy, a repackaging of

other already validated PTSD treatments (e.g. exposure therapy) or a placebo, and whether the eye movements are a red herring: ‘...what is effective in EMDR is not new, and what is new is not effective’ (McNally, 1999, p.619).

The second issue concerns EMDR’s lack of efficacy – notably its perplexing inconsistencies in empirical outcome studies (Sikes & Sikes, 2003) which hinder EMDR’s progress to become an officially recognised evidence-based treatment (EBP)¹ for other disorders. This latter issue, in particular, raises questions about the measurement of psychological therapies in general (efficacy in the research environment versus effectiveness in the real world) and questions the value counselling psychology places on therapeutic approaches that are embedded in

¹ EBP originates from the field of medicine and has been described as: ‘...the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgement that individual clinicians acquire through clinical experience and clinical practice.’ (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996, p.71)

EBP: 'Evidence-based practice is coming and if we do not engage with its implications we shall become as outmoded as medical treatments with leeches...' (Wattis, 2001, cited in Woolfe, Dryden & Strawbridge, 2003, p.660).

This paper critically considers the research literature of EMDR: (1) to present the case of EMDR's unique effects; (2) to question expectations for psychological therapy research in the light of EMDR's inconsistent findings in outcome studies; and (3) to argue for alternative criteria for treatment 'validation' within counselling psychology.

The unique effects of EMDR

To address the first issue, concerning the position of critics who argue that EMDR is nothing more than a repackaged exposure treatment (e.g. Herbert et al., 2000; Lohr et al., 1999; McNally, 1999; Rosen et al., 1998), it is useful to highlight briefly the differences between the protocols of each treatment practice which seem to reflect contrasting theoretical models, one which is well established (exposure therapy) and one that remains elusive to precise definition (although 'Adaptive Information Processing' is favoured by EMDR's founder, Francine Shapiro, 2001, p.3). Exposure therapy is highly directive and moves step-wise towards and through an entire traumatic memory with the client, and makes use of prolonged, uninterrupted and undistracted exposure (Zayfert & Black Becker, 2007). EMDR practice is more associative than directive, focuses on brief rather than prolonged exposure, and on only one segment of the traumatic memory network (Rogers & Silver, 2002). According to strict exposure definition and theory (Marks, 1972) the brief interrupted exposure to traumatic memories in EMDR should actually sensitise not desensitise clients and make their condition worse, however no evidence of this kind exists (Perkins & Rouanzoin, 2002). In a meta-analysis, a direct comparison of the two treatments in terms of treatment time to the relief of symptoms revealed

a contrast of approximately three to six sessions with EMDR and 14 sessions of exposure therapy (Van Etten & Taylor, 1998). By focusing on the practice and effectiveness elements of both therapies in this way, it is clear that profound differences exist between the two (for an in-depth review, see Rogers & Silver, 2002), thus the argument that EMDR is no more than an exposure therapy is supported with difficulty.

EMDR has also been dismissed as a placebo effect (Lohr et al., 1999; McNally, 1999) despite two PTSD wait-list control group studies (Rothbaum, 1997; Wilson, Becker & Tinker, 1997) showing positive findings for the treated groups and despite previous researchers reporting 'unresponsiveness of PTSD to placebo' (Solomon, Gerrity & Muff, 1992, p.634). Van Etten and Taylor (1998) revealed in their meta-analysis that the effect sizes of EMDR were on the whole larger than those of control conditions such as pill placebo, and response rates were maintained over three and 15-month follow-up periods. Thus the treatment effects of EMDR are larger and longer lasting than those expected with PTSD treated by placebo, making it difficult to accept the placebo effect as a plausible interpretation of the findings (Perkins & Rouanzoin, 2002).

The approach most frequently used to support EMDR's effectiveness for exceptional reasons has been the use of 'dismantling studies' (Rosen & Davison, 2003, p.303). The main components unique to EMDR, for example, bilateral eye movements, or another form of dual stimulation, have been studied to rate treatment effects with and without this component (Sikes & Sikes, 2003). The findings of such studies in PTSD clients have been inconsistent. Opponents of EMDR have claimed that eye movements, or other forms of alternating sensory stimulation, do not contribute to the effects of treatment (e.g. Devilly, Spence & Rapee, 1998; Herbert et al., 2000; McNally, 1999; Rosen et al., 1998). However, several of the opponents misquoted or misinterpreted previous research, suggesting that original

sources had not been properly examined (see Perkins & Rouanzoin, 2002) thus leaving their arguments unsupported.

Proponents of EMDR have suggested that alternating eye movements or other forms of dual stimulation (such as Theratappers™², audio or knee/hand tapping) facilitate the integration of information at a neural level (e.g. Levin, Lazrove & van der Kolk, 1999). Studies have indicated that eye movements added significantly positive treatment outcomes (Montgomery & Ayllon, 1994; Wilson et al., 1996), faster processing (Renfrey & Spates, 1994) and reduced vividness of memory (Sharpley, Montgomery & Scalzo, 1996; Lee & Drummond, 2008). A randomised pilot study of a blinded procedure with PTSD clients (therapists remained unaware of the type of stimulation given) was used to evaluate the relative contribution of alternating sensory stimulation versus nonalternating (simultaneous) comparisons (Servan-Schrieber et al., 2006). Findings revealed that the EMDR protocol led to a statistically significant reduction of subjective units of distress irrespective of the nature of the type of stimulation used, but that there was a superiority of alternating stimulation over simultaneous stimulation.

These mixed findings regarding eye movements or other forms of dual stimulation appear to leave the question of their unique effectiveness unanswered and still open to empirical validation. Research has moved in the direction of neuroscience for possible answers (e.g. Elofsson et al., 2008; Lamprecht et al., 2004) but to date an explanation remains elusive.

EMDR and EBP

This paper argues that both sides of the EMDR debate have made their challenges from the same position, the position of EBP, which carries its own problems particularly in relation to the use of randomised control trials (RCTs; Victora, Habicht & Bryce, 2004).

In the case of psychological therapies, RCTs are notoriously poor in predicting outcome at the level of the individual client case from data summarised at the level of group means (Margison et al., 2000). Indeed one major review (Roth & Fonagy, 1996) revealed a lack of evidence concerning many therapies. Most treatments, when studied in this way, have better outcomes than no treatment, and no one treatment is systematically and routinely found to be better for any particular treatment when compared with others. Research and clinical situations are very different and generalising from one to the other is questionable (Fensterheim, 1994; Roth & Fonagy, 2005). The problem of EBP is its insistence on a particular form of 'measurement' and an assumption that if it cannot be measured then it is not 'real' (Hart & Hogan, 2003; Michell, 2003). This rigid stance might be considered to favour those researchers, theorists and practitioners who for personal, political or economic reasons do not want to acknowledge the existence of therapies that challenge the status quo: 'History and the philosophy of science tell us that new approaches often receive widespread opposition from those wedded to previous approaches' (Foa, Davidson & Frances, 2000, p.785).

Early EMDR studies have been criticised for methodological inconsistencies such as inadequate sample sizes, lack of treatment fidelity and too few treatment sessions for clients with multiple traumas (Perkins & Rouanzoin, 2002). Lack of treatment fidelity has been a frequently highlighted difficulty in outcome studies (Sikes & Sikes, 2003). For example, sessions stopped too soon due to therapists' uncertainty about the active treatment while participants' distress was still reducing and before participants reached the necessary level of zero in their rating of subjective units of distress (stage four of the EMDR protocol). Or, shortened protocols through an insufficient course of treatment or the processing of an inadequate number

² A pair of pods to be held, one in each hand, which emit an alternating pulse.

of targets (for multiply traumatised clients such as war veterans) have seriously confused EMDR group design outcome studies (Deville et al., 1998; Macklin et al., 2000). Weak or absent treatment effects are an inevitable result in these truncated studies.

Whilst the wrangling has unfolded, other practitioners have been quietly using their proficiency and clinical expertise to use EMDR with an increasing number of disorders and their findings have been reported in peer reviewed journals. EMDR is now used for panic disorder, obsessive-compulsive disorder, dissociative disorders, dysmorphic body disorder, depression, grief, eating disorders, chronic pain, personality disorders, public-speaking anxiety, somatoform disorders, and many others (Sikes & Sikes, 2003; Manfield, 2003). Preliminary reports suggest EMDR is effective for: substance abuse (Amundsen & Karstad, 2006); treatment of sex offenders (Ricci, 2006); PTSD after childbirth (Sandstrom et al., 2008); choking phobia (de Roos & de Jongh, 2008); migraine headaches (Marcus, 2008); olfactory referencing syndrome (McGoldrick, Begum & Brown, 2008). These studies reveal the benefits in stepping outside the EBP model: 'If it becomes the case that only interventions with an approved evidence-base will be accepted then how can we ever try anything new?' (Hogan & Hart, p.23)

The role for practice-based evidence

This paper suggests that EMDR could be subject instead to a complementary perspective, that of 'practice-based evidence' (PBE) which involves 'gathering good quality data from routine practice' (Margison et al., 2000, p.123) so that 'research is practice led, not the other way around' (Hart & Hogan, 2003, p.24). Margison et al. argued that preferably both paradigms of EBP and PBE are required for psychotherapy to have a robust evidence base, but that EBP could be conducted from data gathered from PBE. They suggested PBE could be a way of measuring therapy within a framework consisting

of seven domains: (1) Interventions at the level of component skills; (2) Case formulation; (3) Treatment integrity; (4) Performance: synthesising adherence, competence and skilfulness; (5) Treatment definitions; (6) Therapeutic alliance; and (7) Routine outcome measurement.

The remaining part of this paper will consider this seven-stage PBE model in the light of EMDR and consider how far the framework could be useful as an alternative starting point to the existing EBP model.

1. Interventions at the level of component skills

This domain represents the micro analysis of a treatment session, such as verbal response modes, which have been rated reliably (Margison et al., 2000). These can be specific to a particular mode of therapy and although there is little 'talk' in EMDR treatment, this could be relevant to 'cognitive interweaves' or to the way the client is asked or helped to decide their negative and positive cognitions. Margison et al. point out that this type of analysis does not easily generalise to the more complex clinical skills such as formulation. Given that it is a requirement of most EMDR training institutions that practitioners should be either accredited therapists or working towards accreditation, it is doubtful that this basic level of scrutiny will contribute much value.

2. Case formulation

This domain represents the macro level of case conceptualisation for the whole treatment. Case formulation was originally developed and found to be a replicable procedure for psychodynamic procedures (Luborsky, 1984). Sharing the formulation with the client helps to maintain trust between the therapist and client and is useful at the end of each session to ensure that the agreed focus was targeted. This translates easily within EMDR treatment in which orientation to the treatment is part of the standard protocol and formulation of the disorder is always part of the procedure. In EMDR treatment, it is at all times the responsibility of

the client to decide the target under focus for the session (Shapiro, 2001).

3. *Treatment integrity*

This domain examines the extent to which treatment procedures are faithfully executed. It is suggested in this PBE model that this covers three aspects: adherence, competence and differentiation. All are critical to the successful outcome of EMDR (Shapiro, 2001). Adherence refers to whether the therapist is using the correct procedures for the therapeutic approach, for example, in EMDR not asking the client to rate their negative cognition, but to rate their positive cognition. Competence is the appropriate delivery of those procedures according to a prior definition, for example, in EMDR knowing when the client is looping (not bringing up new images after the dual stimulation) and using an appropriate cognitive interweave to restart the processing. Differentiation refers to 'whether two or more treatments differ from each other along critical dimensions that are central to their execution' (Kazdin, 1994, in Margison et al., 2000, p.125). As discussed above, the uniqueness of EMDR is still hotly debated but it has been accepted as a unique treatment for PTSD.

4. *Performance: synthesising adherence, competence and skilfulness*

The six levels of skilful competence adopted by this PBE model are level 0 (which represents a harmful state rather than a simple lack of competence) novice, advanced beginner, competent, proficient to expert. The difficulty lies in that 'expert' in many therapeutic approaches suggests an ability to transcend rules and guidelines whereas in EMDR it is essential to stick to the protocol (Shapiro, 2001). 'Expert' competency in EMDR might be considered instead as the skill to treat multiply traumatised individuals and at times to adjust the protocol appropriately according to the disorder (for example, phobias are treated differently from PTSD).

5. *Treatment definitions*

This domain calls for one of two criteria: first, the absolute distinction and differentiation between psychotherapies and this is difficult to ratify regardless of the therapeutic approach chosen (it is acknowledged, for example, that EMDR draws on psychodynamic and cognitive behavioural theories); or second, for the consideration only of those therapies that can be 'manualised' and have well defined methods. Manualised brief therapies, for example, have been shown to have better outcomes than less formalised methods (Crits-Cristoph, 1992). EMDR protocols have been manualised and indeed trainees attending EMDR training are furnished with manuals. EMDR treatment methods are also very well defined.

6. *Therapeutic alliance*

The therapeutic alliance is the most consistent predictor of outcome across many studies in different psychotherapeutic approaches (Henry et al., 1994). Whilst EMDR is not a talking therapy in the same way as cognitive behavioural therapy (CBT), for example, the development of a therapeutic alliance is still considered to be an absolute necessity (Shapiro, 2001).

7. *Routine outcome measurement*

Outcome measures are numerous and are sometimes disorder specific. Within EMDR, it would be necessary to use a measure that assessed the disorder under treatment. A general outcome measure, such as the Clinical Outcomes in Routine Evaluation (Core System Group, 1998) and a specific measure could then be utilised in an 'effectiveness framework using the concepts and methods of reliable and clinically significant change' (Margison et al., 2000, p.127). Individual clients' observed differences between scores could be plotted on a two-dimensional graph where the x-axis represents the pre-treatment score and the y-axis represents the post-treatment score on the same instrument. The centre diagonal line would represent no change and tramlines either side

would represent change possibly attributed to chance, thus only scores falling below the lower diagonal would reliably show improvement while those above would show deterioration. Margison et al. acknowledged that some technical difficulties needed to be overcome (such as skewed distributions) but the chart would show at a glance whether the individual had moved from a dysfunctional to a more functional sample of scores.

An infrastructure would be needed such as 'Practice Research Networks' (PRNs; Zarin, West, Pincus et al., 1996, in Margison et al., 2000, p.128) to contain and monitor a PBE model of this type. This would involve a large number of interested clinicians who would collect and report data resulting in large datasets that could then be used for EBP purposes. PRNs are often affiliated to particular academic institutions to help the central dissemination of results. In the case of EMDR, institutions such as Birmingham University which is already on the brink of introducing a Masters programme in EMDR (Farrell, 2008) might be an appropriate institution for data-collection. In this way, real world data could be collected from actual practice settings rather than 'specifically orchestrated clinical trials' (Margison et al., 2000, p.128).

Conclusion

This review has critically discussed the controversy surrounding EMDR. The debate surrounding the unique effectiveness of EMDR has been presented and the problematic use of traditional EBP in the assessment of EMDR has been discussed. An alternative starting point for treatment validation, PBE, has been presented as a potential framework of seven domains within a Practice Research Network, and the applicability of PBE to

EMDR has been presented at each stage. Clearly there needs to be some framework within which therapies can be monitored for the protection of the public. The EMDR International Association (EMDRIA, 2008) makes it clear that licensure in a mental health profession is a pre-requisite for EMDR training or students must be in licensing tracks under appropriate supervision. PBE would allow EMDR to be trialled in real clinical settings for a range of disorders instead of remaining at the mercy of the traditional EBP route, potentially never to attain 'validation'. PBE would also, importantly, allow for new therapeutic approaches to be offered to practitioners such as counselling psychologists who at present are only taught the skills of two approaches during their three years of training, usually CBT and one other. EMDR in particular, with its focus on the effects of trauma on the mind and body, captures the experiential humanistic essence of counselling psychology described by Gendlin (1996). There is a risk that we will close off the routes to new and even well-established effective therapies if we restrict ourselves to EBP. For example, the Improving Access to Psychological Therapies (IAPT, 2008) scheme, initiated and funded by the government, is almost exclusively devoted to CBT and marketed as an EBP. The danger is closer than we think.

Correspondence

Joanna Nowill

Counselling Psychologist in Training,
c/o MC103 Counselling Psychology,
Psychology Division,
Millennium City Building,
University of Wolverhampton,
Wolverhampton WV1 1SB.
E-mail: jo.nowill@btinternet.com

References

- Amundsen, J.E. & Karstad, K. (2006). Integrating EMDR and the treatment of substance abuse. *Tidsskrift for Norsk Psykologforening*, 43, 469.
- Bae, H., Kim, D. & Park, Y.C. (2008). Eye movement desensitisation and reprocessing for adolescent depression. *Psychiatry Investigation*, 5, 60–65.
- Bisson, J.I., Ehlers, A., Matthews, R., Pilling, S., Richards, D. & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder. *British Journal of Psychiatry*, 190, 97–104.
- Core System Group (1998). *CORE System (Information Management) Handbook*. Leeds: Core System Group.
- Crits-Cristoph, P. (1992). The efficacy of brief dynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry*, 149, 151–158.
- de Roos, C. & de Jongh, A. (2008). EMDR treatment of children and adolescents with a choking phobia. *Journal of EMDR Practice and Research*, 2(3), 201–211.
- Devilly, G.J., Spence, S.H. & Rapee, R.M. (1998). Statistical and reliable change with eye movement desensitisation and reprocessing. Treating trauma within a veteran population. *Behaviour Therapy*, 29, 435–455.
- Elofsson, U.O., von Scheele, B., Theorell, T. & Sondergaard, H. P. (2008). Physiological correlates of eye movement desensitisation and reprocessing. *Journal of Anxiety Disorders*, 22(4), 622–634.
- EMDR International Association (2008). *EMDR/IA eligibility requirements for the basic EMDR training*. Retrieved 6 November 2008 from: www.emdria.org/displaycommon.cfm?an=1&subarticlenbr=36
- Farrell, D. (2008). *EMDR as an effective intervention in psychological trauma*. Paper presented at the meeting of the Central England Counselling Psychology Forum, AGM Event, Birmingham.
- Fensterheim, H. (1994). Outcome research and clinical practice. *The Behaviour Therapist*, 17, 140.
- Foa, E.B., Davidson, J.R.T. & Frances, A. (2000). Further discussion of EMDR for treatment of PTSD. *Journal of Clinical Psychiatry*, 61, 785.
- Gendlin, E.T. (1996). *Focusing-oriented psychotherapy: A manual of the experiential method*. New York: Guilford Press.
- Hart, N. & Hogan, K. (2003). Second response: Training counselling psychologists: What role for evidence-based practice? *Counselling Psychology Review*, 18(3), 21–27.
- Henry, W.P., Strupp, Schacht, T.E. & Gaston, L. (1994). Psychodynamic approaches. In A. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (4th ed., pp.467–508). London: Wiley.
- Herbert, J.D., Lilienfeld, S.O., Lohr, J.M., Montgomery, R.W., O'Donohue, W.T., Rosen, G.M. & Tolin, D.F. (2000). Science and pseudoscience in the development of eye movement desensitisation and reprocessing: Implications for clinical psychology. *Clinical Psychology Review*, 20, 945–971.
- IAPT (2008). *Improving access to psychological therapies*. Retrieved 4 November 2008 from: www.iapt.nhs.uk/
- Lamprecht, F., Kohnke, C., Lempa, W., Sack, M., Matze, M. & Munte, T.F. (2004). Event-related potentials and EMDR treatment of post-traumatic stress disorder. *Neuroscience Research*, 49, 267–272.
- Lee, C.W. & Drummond, P.D. (2008). Effects of eye movement versus therapist instructions on the processing of distressing memories. *Journal of Anxiety Disorders*, 22(5), 801–808.
- Levin, P., Lazrove, S. & van der Kilk, B.A. (1999). What psychological testing and neuroimaging tell us about the treatment of post-traumatic stress disorder by eye movement desensitisation and reprocessing. *Journal of Anxiety Disorders*, 13, 159–172.
- Lohr, J.M., Lilienfeld, S.O., Tolin, D.F. & Herbert, J.D. (1999). Eye movement desensitisation and reprocessing: An analysis of specific versus non-specific treatment factors. *Journal of Anxiety Disorders*, 13, 185–207.
- Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment*. New York: Basic Books.
- Macklin, M.L., Metzger, L.J., Lasko, N.B., Berry, N.J., Orr, S.P. & Pitman, R.K. (2000). Five-year follow-up of eye movement desensitisation and reprocessing therapy for combat-related post-traumatic stress disorder. *Comprehensive Psychiatry*, 41, 24–27.
- Manfield, P. (Ed.) (2003). *EMDR casebook* (2nd ed.). London: Norton.
- Marcus, S.V. (2008). Phase 1 of Integrated EMDR: An abortive treatment for migraine headaches. *Journal of EMDR Practice and Research*, 2(1), 15–25.
- Margison, F.R., Barkham, M., Evans, C., McGrath, G., Clark, J.M., Audin, K. & Connell, J. (2000). Measurement and psychotherapy: Evidence-based practice and practice-based evidence. *British Journal of Psychiatry*, 177, 123–130.
- Marks, L.M. (1972). Flooding (implosion) and allied treatments. In W.S. Agras (Ed.). *Behaviour modification: Principles and clinical applications* (pp.151–213). Boston, MA: Little Brown.
- McGoldrick, T., Begum, M. & Brown, K. W. (2008). EMDR and olfactory reference syndrome: A case series. *Journal of EMDR Practice and Research*, 2(1), 63–68.

- McNally, R. (1999). EMDR and mesmerism: A comparative historical analysis. *Journal of Anxiety Disorders*, 13, 225–236.
- Michell, J. (2003). The qualitative imperative. Positivism, naïve realism and the place of qualitative methods in psychology. *Theory and Psychology*, 13, 5–31.
- Montgomery, R.W. & Ayllon, T. (1994). Eye movement desensitisation across subjects: Subjective and physiological measures of treatment efficacy. *Journal of Behaviour Therapy and Experimental Psychiatry*, 25, 217–230.
- National Institute for Health and Clinical Excellence (2005). *Post-traumatic stress disorder*. Retrieved 2 November 2008 from: www.nice.org.uk/Guidance/CG26
- Perkins, B.R. & Rouanzoin, C.C. (2002). A critical evaluation of current views regarding eye movement desensitisation and reprocessing (EMDR): Clarifying points of confusion. *Journal of Clinical Psychology*, 58, 77–97.
- Renfrey, G. & Spates, C.R. (1994). Eye movement desensitisation: A partial dismantling study. *Journal of Behaviour Therapy and Experimental Psychiatry*, 25, 231–239.
- Ricci, R.J. (2006). Trauma resolution using eye movement desensitisation and reprocessing with an incestuous sex offender: An instrumental case study. *Clinical Case Studies*, 5, 248.
- Rogers, S. & Silver, S.M. (2002). Is EMDR an exposure therapy? A review of trauma protocols. *Journal of Clinical Psychology*, 58, 43–59.
- Rosen, G.M. & Davison, G.C. (2003). Psychology should list empirically supported principles of change (ESPs) and not credential trademarked therapies or other treatment packages. *Behaviour Modification*, 27, 300–312.
- Rosen, G.M., Lohr, J.M., McNally, R.J. & Herbert, J.D. (1998). Power therapies, miraculous claims and the cures that fail. *Behaviour and Cognitive Psychotherapy*, 26, 99–101.
- Roth, P. & Fonagy, A. (1996). *What works for whom?* London: Guilford Press.
- Roth, P. & Fonagy, A. (2005). *What works for whom?* (2nd ed.). London: Guilford Press.
- Rothbaum, B.O. (1997). A controlled study of eye movement desensitisation and reprocessing for post-traumatic stress disorder sexual assault victims. *Bulletin of the Menninger Clinic*, 61, 317–334.
- Sackett, D.L., Rosenberg, W., Gray, J.A., Haynes, R.B. & Richardson, W.S. (1996). Evidence-based medicine: What it is and what it isn't. *British Medical Journal*, 312, 71–72.
- Sandstrom, M., Wiberg, B., Wikman, M., Willman, A.K. & Hogberg, U. (2008). A pilot study of eye movement desensitisation and reprocessing treatment (EMDR) for post-traumatic stress after childbirth. *Midwifery*, 24, 62–73.
- Servan-Schreiber, D., Schooler, J., Dew, M.A., Carter, C. & Bartone, P. (2006). Eye movement desensitisation and reprocessing for post-traumatic stress disorder: A pilot blinded, randomised study of stimulation type. *Psychotherapy and Psychosomatics*, 75, 290–297.
- Shapiro, F. (2001). *Eye movement desensitisation and reprocessing: Basic principles, protocols and procedures* (2nd ed.). London: Guilford Press.
- Sharpley, C.F., Montgomery, I.M. & Scalzo, L.A. (1996). Comparative efficacy of EMDR and alternative procedures in reducing the vividness of mental images. *Scandinavian Journal of Behaviour Therapy*, 25, 37–42.
- Sikes, C. & Sikes, V. (2003). EMDR: Why the controversy? *Traumatology*, 9, 169–181.
- Solomon, S.D., Gerrity, E.T. & Fuff, A.M. (1992). Efficacy of treatments for post-traumatic stress disorder. *Journal of the American Medical Association*, 268, 633–638.
- Van Etten, M. & Taylor, S. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis. *Clinical Psychology and Psychotherapy*, 5, 126–144.
- Victoria, C.G., Habicht, J.P. & Bryce, J. (2004). Evidence-based public health, moving beyond randomised trials. *American Journal of Public Health*, 94, 400–405.
- Wattis, E. (2001). Unpublished keynote address: The future of counselling. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.) (2003), *Handbook of counselling psychology* (2nd ed.). London: Sage.
- Wilson, S.A., Becker, L.A. & Tinker, R.H. (1995). Eye movement desensitisation and reprocessing (EMDR) treatment for psychologically traumatised individuals. *Journal of Consulting and Clinical Psychology*, 63, 928–937.
- Wilson, S.A., Silver, S.M., Covi, W.G. & Foster, S. (1996). Eye movement desensitisation and reprocessing: Effectiveness and autonomic correlates. *Journal of Behaviour Therapy and Experimental Psychiatry*, 27, 219–229.
- Zayfert, C. & Black Becker, C. (2007). *Cognitive behavioural therapy for PTSD: A case formulation approach*. London: Guilford Press.

Notes

Notes