BACP

Children, Young People & Families

For counsellors and psychotherapists working with young people

December 2023

Contents

Featured article

Voices

BACP Children, Young People & Families is the quarterly professional journal for counsellors and psychotherapists working with children and young people.

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Regulars

In practice

From the Editor

Neither counselling, therapy nor publishing take place in a vacuum, and it is therefore imperative that we take time to consider the social, environmental and, yes, political contexts in which we work. Some readers may find that statement contentious, while others will welcome it with a sigh of, 'At last'. Whatever your reaction, I invite you to consider how your position of privilege/under-privilege, ethnicity, gender, sexuality, age and social class influence your biases and assumptions – we all have them, and they influence our every thought and (re)action, inside and outside the counselling room. I also invite you to ponder the question, 'How does what's happening 'out there' in the world effect what's going on 'in here' in the room?', a question which has woven its way throughout this issue.

I invite you to consider how your position of privilege/ under-privilege, ethnicity, gender, sexuality, age and social class influence your biases and assumptions – we all have them

In **Honest and curious** (p11), Kate Saunders shares how she is supported to talk about sex and reproductive health with her clients by the Welsh Government's new Relationships and Sexuality Education (RSE) curriculum; that's political. In **Difficult parent or traumatised parent?** (p20), co-authors from the Parent Carer Trauma Working Group discuss how hard it is for parent carers of children with special educational needs and disabilities (SEND) to navigate educational, health and social care systems; that's political. Aleesha Khan takes a more overt position in **Why therapy is political** (p25), in which she urges us to address issues of identity and cultural competency in counselling.

We've got the social and environmental contexts covered too. In **Muddy waters** (p29), Phoebe Johnson discusses her dilemmas around confidentiality and information-sharing in her work with adolescents, while Sue Kegerreis explores the pros and cons of training larger cohorts of counselling students in her regular column (p18).

I have revised an article I wrote for this journal in 2011, about the potential impact of chaos and violence in the home and online through a 2023 lens. **Where lunatics (still) prosper** (p06) feels just as relevant today as it did then, in the context of almost daily reports of misogynistic media and gender-based violence; that's social, environmental *and* political, and it's our featured article.

Back in the room, there are two pieces in this issue which share the same title, **Just listening**, for which I make no apology. Elizabeth Holt demonstrates the ways she supports supervisees to listen to their clients (p19), while Mary Alexander uses poetry to illustrate listening to adolescents (p24). Both subtly challenge the misconception of the prefix 'just'.

If you've been wondering whether you have what it takes to write an article for this journal, read my responses to the questions I am frequently asked about the requirements in **Do you have what it takes?** (p30). It might sound easier or harder than you assumed, but if you have the right sort of skills and enthusiasm, I would love to hear from you; please get in touch in the usual way.

Finally, I would like to extend my congratulations to BACP's events team and Private Practice Executive Committee. The 2022 BACP Private Practice Conference, 'Beyond the room – finding your inner entrepreneur', was highly commended in the Best Virtual/Hybrid Event category at the Memcom Excellence Awards. I was there, and agree it was an excellent event. Bookings are open for BACP's CYPF Conference on 9 March 2024. 'Neurodiversity: the therapeutic encounter' is also shaping up to be commendable. Presenters will share a wealth of experience and there will be opportunities for networking with fellow divisional members. I'll be at the venue, so do come and say hello!

Jeanine Connor
Editor

Get in touch
If you would like to write a response to anything in this issue, or wish to write a review or submit a proposal for an article, contact me at **cypf.editorial@bacp.co.uk**. Please do not send unsolicited articles.

Leading the way

Divisional news, including updates from BACP's CYPF Lead **Jo Holmes** and BACP CYPF Executive Committee Chair **Emma Davies**

Changemakers coalition

BACP's CYPF Lead Jo Holmes has been attending a monthly changemakers coalition group led by the NSPCC, formed in response to the recommendations outlined in the Independent Inquiry into Child Sexual Abuse (IICSA). The group, made up of those with lived experience, as well as a range of service providers and leading charities, aims to influence government policy, and ensure that the recommendations made by victims and survivors of child sexual abuse are central. The group's mission is to prevent child sexual abuse, and provide much improved support to victims and survivors. The group submitted a joint response to the Government's consultation on the IICSA recommendation around mandatory reporting of child sexual abuse, with BACP highlighting anomalies between what is considered regulated and unregulated practice. This could potentially result in mandatory reporting for those working in services, but not those working in private practice.

https://scrqualitymarkers-scie.nspcc.org.uk/globalassets/documents/iicsa-changemakers-press-releases/mandatory-reporting-consultation-submission-2023.pdf

Collaboration in Northern Ireland

BACP Children and Families Lead Jo Holmes and Four Nations Lead Steve Mulligan have been working in partnership with counselling providers, and the young people's campaign group, Pure Mental, to launch a report, *The Case for Investing in Therapeutic Interventions in Northern Ireland*. The report includes the voices of children, young people, parents, teachers, school leaders, professional membership bodies and politicians from all parties in Northern Ireland to support a call on UK Government to restore funding for counselling services in primary schools, and agree the long-term commissioning of therapeutic interventions in secondary schools, as currently delivered through the Independent Counselling Service for Schools programme.

www.puremental.org

Law Commission consultation

BACP's CYPF Lead Jo Holmes worked with the Law Commission to host a consultation event to gather member views on proposed reforms around how evidence is used in sexual offence prosecutions in England and Wales, including the law, guidance and practice relating to the trial process. One of the proposed reforms was to put additional safeguards in place to ensure counsellor notes could only be requested by a high court judge. A full report with key recommendations will be published next year.

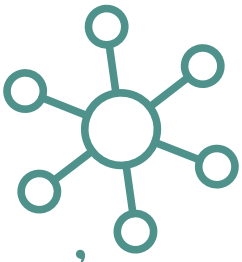
Expert Reference Group

The school-based counselling Expert Reference Group (ERG) has successfully completed its third academic year, with representative members from across the four nations working in a variety of school, college, agency, third sector, private practice and training-based settings. Looking forward, the ERG is focusing on a number of key issues, including ongoing campaign work for funded counselling provision in England, sustainable funding models across Northern Ireland to include primary school counselling, and focusing on work to improve pay and conditions for the profession.

Fund the Hubs

BACP's CYPF Lead Jo Holmes has been working closely with key partner organisations to secure government funding for up to 12 Early Help hubs across England, for a one-year period from January 2024 to April 2025. Although the funding is short term, there will be built-in evaluation looking at shared outcomes around wellbeing, health inequalities and employability. The provision of counselling for young people up to the age of 25 is built into the service specification, with representatives from a variety of counselling services from across England taking part in a workshop with the Department for Health and Social Care (DHSC) to discuss outcome measures currently used. BACP's Senior Research Fellow, Charlie Duncan, has also advised the DHSC on outcome measures.

www.bacp.co.uk/news/news-from-bacp/2023/28-september-new-government-funding-for-early-intervention-mental-health-hubs-for-children-and-young-people



School counsellors' network

BACP's CYPF Lead Jo Holmes presented an overview of children and young people's policy work within the counselling profession at a newly established network group for school counsellors in England, hosted by Dr Marilyn McGowan from Iron Mill College in Exeter. Richard Bagnall-Oakley from the Psychotherapy and Counselling Union (PCU) also talked about the benefits of union involvement, particularly linked to pay and conditions.

Find out how to join future events by contacting: marketing@ironmill.co.uk.

From the Chair

With a blink of an eye, 2023 is drawing to a close and 2024 is in sight, prompting me to think about endings and beginnings. For the BACP CYPF Executive Committee, it is not just the end of a year, but the end of an era, as we say farewell to three of our long-standing committee members who are reaching the end of their tenure. Sue Pattison has served as co-Chair and played a valuable role in carrying out research within BACP, including initial research in respect of school counselling provision in Wales. We have also benefitted from Sue's expertise in the area of learning disabilities. Wendy Hay has served as Deputy Chair of the CYPF Executive Committee during a period of recruitment and change, providing a sense of stability and clarity to the Executive Committee throughout her tenure. Alongside representing her Scottish colleagues, Wendy has shared a particular interest in counselling within the boarding school sector.

During Edith Bell's time on the CYPF Executive Committee, we have benefitted from her knowledge of organisational issues, and her significant understanding of how the voluntary sector interfaces with government departments, especially in relation to health and education. Thank you, Wendy, Edith and Sue for your commitment to children, young people and families.

The new year will bring new opportunities for the Executive Committee, including recruiting new members and diversifying the board. We move forward with a new BACP strategy, new key priorities, and the responsibility to continue to improve. First on the agenda is the BACP CYPF Conference in March 2024, with plans underway to make it our best event yet. Divisional members voted on neurodiversity as the theme, and this is a great opportunity for the Executive Committee and divisional members to work together to implement BACP's equality, diversity and inclusion (EDI) strategy. With over 60 applications received from potential presenters, we have been working closely with the events team to consolidate the programme. A big thank you to members who provided valuable feedback from last year's event. We are paying close attention to this with a view to making improvements. To book and for more information, visit: www.bacp.co.uk/events/cyp2024-bacp-cypf-conference-2024/. The event is scheduled to take place in London and online on Saturday 9 March 2024.

Building on the theme of inclusivity, at our last Executive Committee meeting, we discussed next steps for enhancing the CYPF platform by involving young people directly. The aim is to set up an event and share key learning and feedback directly with divisional members, as part of our agenda to promote the young person's voice across the profession. We will bring you more details soon about how you can get involved in this.

Divisional members voted on neurodiversity as the theme [for the BACP CYPF Conference], and this is a great opportunity for the Executive Committee and divisional members to work together to implement BACP's equality, diversity and inclusion (EDI) strategy

Supporting primary school children and parents is one of our priorities. As part of this agenda, I met with one of the authors of research recently published about how parent mental health and child mental health is intertwined. We spoke about the findings from *The indivisibility of parental and child mental health and why poverty matters*.[1] I will present these findings at our next Executive Committee meeting, where we will continue to explore the evidence base for effective counselling and psychological wellbeing support to younger children and families.

Emma Davies, BACP CYPF Executive Committee Chair

1 Treanor M, Troncoso P. The indivisibility of parental and child mental health and why poverty matters. Journal of Adolescent Health 2023; 73: 470–477.

Where lunatics (still) prosper

Jeanine Connor revisits an article, first published in this journal in 2011, in which she examined the impact on children of exposure to sex and violence online and in the home

The title of the original article, 'Where lunatics prosper', was the tagline from *Grand Theft Auto III* (GTA),[1] a console game for adults aged 18 and over. One of the mainstays of this and similar 18+ games, regularly played by some children as young as six, is violence. Injury and death are portrayed in graphic detail as dying bodies are hurled through the air, and bullets cut through flesh, splattering blood across the screen. A character in *Call of Duty* (COD)[2] opens fire in a busy airport, killing innocent bystanders so that he can progress to the next level. I was informed of this by an 11-year-old boy who told me, 'I don't know what I would do if I was ever in a real airport with a real gun.' God forbid.

According to the marketing hype for Black Ops,[3] from the COD series, players are able to 'turn down the blood and turn off the profanity to suit their needs'. There is no question in my mind that the amount of blood and profanity a child 'needs' is zero, yet the prepubescent boys who play these games seem most unlikely to censor them. The other feature of these games is graphic sexual content. In GTA III, the character/gamer acts out sexually explicit scenes. In GTA IV,[4] he picks up prostitutes and selects from three levels of service: masturbation, fellatio and full sexual intercourse. Boys aged 16, 12, eight, even six, spend several hours a day orchestrating graphic, and sometimes violent, sex with prostitutes. Once they're done, they can choose to pay for the services, or kill the women who provide them.

I wonder how they'll behave when they grow up and meet a real woman for sex in real life? Usually, parents consent to and purchase the 18+ games for their children because the children are too young to do so. I think the content is far more impactful than watching porn, which the same parents are likely to object to; at least with porn, the viewer is merely a voyeur; with gaming, they are an actively participating protagonist.

I maintain that children living in an environment furnished with chaos and violence are likely to present as chaotic and violent, or emotionally shut-off, or socially isolated, and sometimes this can resemble the characteristics of attention deficit hyperactivity disorder (ADHD) or autistic spectrum condition (ASC). I remain troubled by the popularity of 18+ games among under-18s, and by both the computer-generated and off-screen chaos and violence which furnishes many of their worlds. This isn't about attacking gamers, or jumping on the overcrowded bandwagon peddling the notion that gaming is the root of all evil, and nor is it about diminishing the value of thoughtful, holistic assessment and diagnosis. Misunderstanding often fuels sensationalist headlines, and I don't want to fall prey to that either; I want instead to encourage a consideration of the internal and external realities of young people whose presentation resembles ADHD or autism.

Risk factors

A study of 10- and 11-year-old children, conducted by Bristol University, found that playing computer games for more than two hours a day increased the risk of mental health problems by 60%.[5] This is a scary statistic but, like most statistics, it does not really mean very much to most people. I'm not someone who thinks that all gaming is all bad for all players, but I do have concerns about some types of game played by some young people. Gamers are often rewarded for action, speed and progressing to higher levels by fair means or foul (legal 'cheats' are readily available online). When parents and teachers lament children's inability to concentrate, and despair about their uncontrollability and academic failings, I wonder about gaming. When I hear about boys who are violent to siblings and peers, who use sexually explicit language and who seem devoid of empathy, I speak to them about their interests. In many instances, I learn that they enjoy adult games in which they are vicariously rewarded for killing and having sex, and where the role of females is merely to provide visual and sexual gratification. Often, the children are gaming for several hours every day and all weekend, often fuelled by caffeine from energy drinks.

As with most things, context is paramount, and my clinical experience highlights numerous risk factors. What if the children who are playing violent and sexually violent games are growing up in families where boundaries are permeable, or where they have witnessed aggression and violence, or experienced trauma, neglect or abuse? The evidence suggests that these children are four times as likely as those who are not deprived or disadvantaged to develop a formal mental illness.[6] (When I first wrote this article 12 years ago, the statistic was *twice* as likely). In order to escape their despicable realities, children retreat into a fantasy world, often online. In doing so, they form identifications with fantasy characters who are fighters, killers and abusers of women, in order to defend against their own vulnerability. With a gun in their (virtual) hand and a virtually naked female to provide sexual gratification at the push of a button, these children can, at last, feel omnipotent.

With a gun in their (virtual) hand and a virtually naked female to provide sexual gratification at the push of a button, these children can, at last, feel omnipotent

Is there really a problem?

The escalation continues in the number of referrals to mental health services for boys (in particular) who are unable to concentrate, are failing academically, have no impulse control, and a tendency to act out with violence or aggression. 'Do they have ADHD?' the referrer asks. What about the children who are lacking in empathy, obsessional, hypervigilant and overly sensitive? Should we diagnose them with autism? In both types of referral, a mental health diagnosis is sought in order to explain the child's behaviour and, in some cases, a drug to control it. It makes sense – the children present with clinical characteristics listed in diagnostic manuals such as DSM-IV,[7] or looked up on the internet by baffled parents. I recognise the merits of thoughtful diagnosis and treatment, but to label a child in haste, and without an exploration of context, is tantamount to imposing one's own version of reality on to an individual whose sense of reality is already confused. It's like saying, 'I shall view you and define you in this particular way, and completely ignore your own experience of who and what you are'.[8] It is also worth noting that fetal alcohol syndrome (FAS), a widely under-diagnosed condition, looks very much like ADHD and in some cases, ASC. Any mental health assessment is incomplete if we ignore the child's family and environmental experiences. To do so may result in a neat diagnosis, but it can also leave a child exposed to risk and potentially long-term damage.

Rather than jump to conclusions and hasty diagnoses, I think it's more helpful to consider what the ADHD-*like* and ASC-*like* presentations might be telling us. In my clinical experience, latency-aged boys (in particular) who have been allowed to play age and developmentally inappropriate console games, and/or have witnessed chaos or abuse at home, are highly likely to present as aggressive, with an inability to concentrate, show little or no impulse control, and/or obsessional, hypervigilant behaviour and be lacking in empathy. All behaviour is a communication – it's the job of anyone who supports children to take notice of what it's telling us, not simply label it.

Case study

Nine-year-old Darnell was referred for a mental health assessment by his GP who stated that he met every one of the criteria for ADHD and a diagnosis was inevitable. He was described as hyperactive and inattentive, aggressive to his peers, particularly girls, and he used sexualised language and behaviour. He could not be left unattended with his four-year-old sister for fear he would hurt her. He was failing academically and had been suspended from school on numerous occasions, with a threat of permanent exclusion if his behaviour could not be tamed.

At assessment, I met with Darnell, his sister Jess and their mother Becky, who was heavily pregnant and showed signs of bruising to her face. She told me that Darnell was uncontrollable and refused to do as he was told. He said he hated her, she was a slag, and he wished she would just f*ck off. Becky told me that Darnell had previously stated that he wanted to kill her, and also that he wanted to die. She said that even as a baby, he was 'difficult', whereas Jess was always a much easier child. Jess did indeed remain calm and unusually quiet for a four-year-old throughout the assessment, whereas Darnell sneered and groaned. He broke one of the toys, perhaps on purpose, and devoured a packet of tissues by chewing them up and spitting them out.

I learnt that Darnell was an unplanned baby. Becky was 18 and had been in a relationship with his father for a few months when she discovered she was pregnant. They lived separately with their own parents for most of the pregnancy, until they moved into social services funded accommodation prior to Darnell's birth.

Becky reported that Darnell's father drank a lot 'because of stress', and was sometimes violent. She said he punched her in the stomach when she was pregnant, and she gave birth with a black eye. She believed that he loved her and wanted their baby, but following Darnell's birth, the violence 'got really bad'. The relationship ended when he went to prison, and she began a relationship with his friend who had been 'really supportive at first'. But then he raped her, and she became pregnant with her daughter, telling no one the details of the conception, but telling me matter-of-factly in front of both her children. Becky had been in her current relationship for eight months with a man who was the father of her unborn baby, whom she described as 'like a third child'. She admitted that they had heated arguments, and sometimes 'use each other as punch bags to let off steam'.

When I spoke to Darnell alone, he told me that he hated his mum's partner because he was 'f*cking mean' and a 'lazy c*nt'. Darnell had learnt that if he played up at school, he could go home, and make sure his mum was OK. He told me that the police came again yesterday because mum's partner hit her because he thought the baby wasn't his. Darnell repeated that his mum was a slag. He said he tried not to be too bad because he was scared he would be taken into care like his older brother, a child I had not been aware existed, but who I later learnt was in foster care due to emotional and physical neglect. I expressed my concern about Darnell's situation, stating very clearly that it was not OK for grown-ups to hurt each other, or to make children feel frightened. He admitted that he sometimes felt sad, but 'not frightened because I'm not f*cking gay'.

I asked Darnell what he liked to do when he wasn't at school and he gave the inevitable response of 'Xbox'. Fearing the answer, I asked which games he liked and he became animated for the first time during the assessment, and said he liked GTA and had just got the new one for his ninth birthday. I commented on how excited he seemed and wondered aloud what it was that he enjoyed about the games. He said simply, 'Sex and killing.'

Urban neglect

Darnell is illustrative of countless young boys whose lives consist of real and virtual violence who present with ADHD-like behaviours. Their lives are messy, unsafe and without boundaries, and so it should be no surprise that they present as chaotic, at risk and uncontrollable. They 'create havoc at home and school … as if they were spilling out all over the place'[8] because they are communicating their lived and online experiences. Children like Jess are also at risk but many go unnoticed. They are compliant and expend their energy ensuring that there is no mess and no chaos as an antithesis to their messy and chaotic lives. They are often hypervigilant to noise and notice everything. As they get older, they may switch off emotionally and end up in GP surgeries and mental health clinics presenting with ASC-like behaviours.

Children are harmed by exposure to violent and sexual imagery and language, be it in the home or on the screen. Adults who allow this to happen may be guilty of social and emotional neglect, or what has been termed 'urban neglect through technology'.[9] Psychodynamic literature emphasises the importance of infant-caregiver attachment, yet for many children, early 'care' is provided by a screen portraying sex and violence. For some children, this provides a mirror to their external lives, so that fantasy and reality become inextricably tangled. In the absence of an alternative father role model, the process of identity formation for prepubescent and adolescent boys becomes enmeshed with on-screen characters, who are an exaggerated version of themselves.[10] These boys crave 'raw, loud and angry … because they need it to be strong enough to match and master their [own] anxiety and anger.'[11]

Rather than jump to conclusions and hasty diagnoses, I think it's more helpful to consider what the ADHD-*like* and ASC-*like* presentations might be telling us

Society has, on the whole, turned a collective blind eye. Instead, the media spotlight continues to highlight the potential impact of provocative clothing on young girls, which, it is argued, leads to their premature sexualisation. Yet, the spotlight has merely flashed over their male counterparts who, while their female peers play dress-up, are simulating oral sex and bloody violence. Twelve years after this article was first published, reports of murder, rape and domestic abuse remain more focused on female provocation than on male gaming habits. The future I feared is indeed a place 'where lunatics prosper'.[1] ■

Jeanine Connor is a psychodynamic psychotherapist, supervisor, training facilitator and editor of this journal. She is the author of two books about psychotherapy with CYPF – *Stop F*cking Nodding and Other Things 16 Year Olds Say in Therapy* (PCCS Books, 2022) and *Reflective Practice in Child and Adolescent Psychotherapy: listening to young people* (Routledge, 2020). Her third psychotherapy book will be published in 2024.
www.seapsychotherapy.co.uk

This article is based on *Where Lunatics Prosper* which was first published in this journal in September 2011: www.bacp.co.uk/bacp-journals/bacp-children-young-people-and-families-journal/september-2011/where-lunatics-prosper

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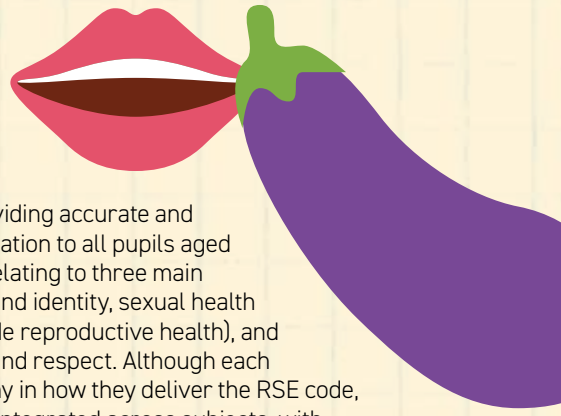
Honest *and* curious

Kate Saunders shares the ways that being honest and curious about sex can open up conversations in the counselling room

I'd been wondering whether different counsellors tend to draw out different conversational topics in sessions with clients, and took this idea to supervision. My supervisor commented that she'd noticed that one of the main threads to my client work was the topic of sex and reproductive health, and we reflected on why this might be. I'm interested in sex; the messy, raw, humanness of it all; and, as a teenager, I was fascinated by it too, as were pretty much all of my peers. However, as an adolescent, finding out accurate information about sex, let alone being able to have a meaningful conversation with someone about how it related to me, and how I felt about it, was difficult to come by. Conversations with peers ran the risk of me appearing (accurately) inexperienced, or worse – 'slutty', while sex and periods were only ever mentioned by adults in a clinical way that tended towards the negative. I remember being terrified of ever having a boyfriend after my first sex education class in secondary school – which boiled down to an hour of learning about sexually transmitted infections (STI), watching a graphic video of a woman giving birth, and being warned of the dangers of teenage pregnancy. My experience of discovering my own sexuality and emerging womanhood was lonely, and conversations with adults about experiences that might relate to pleasure in any way felt off-limits.

Around the time that I qualified as a counsellor for children and young people, I read *Horny and Hormonal* by Nick Luxmoore,[1] a book that has been hugely influential on me, and highlights the importance of



counsellors offering sex and sexuality as a welcome and valid topic of conversation in the counselling room. I wanted to be a counsellor who was up for having conversations that mattered, and I understood that I was going to need to be proactive in my approach in offering up issues that can often be met by other adults in our clients' lives with unease and discomfort. Part of my way of working as a school-based counsellor is to share referral information with the client, and to assess for risk and support structures using a CORE form, which is a questionnaire that can be used to assess risk, support structures, and monitor and record outcome measures.

Working in this way naturally offers up conversational leads to potentially important issues that might otherwise be missed by both parties for a number of reasons: fear of taboo, not knowing how to bring it up, or fear of overstepping a line. School-based counselling is often a novel experience for young people; it is unusual to be able to swear in school and not get told off, and it is unusual to be able to talk freely about anything, yes, anything, including sex. As the professional adult in the relationship, we have a responsibility to lay out the parameters of therapy, and this includes normalising a range of conversational topics, and giving our clients permission to talk about issues that they may not feel able to talk about elsewhere.

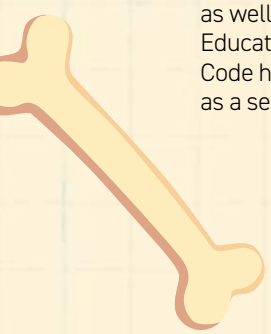
...we have a responsibility to lay out the parameters of therapy, and this includes normalising a range of conversational topics, and giving our clients permission to talk about issues [such as sex]

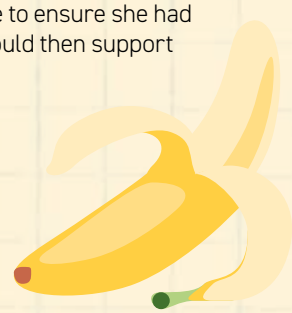
Supportive framework

According to The British National Surveys of Sexual Attitudes and Lifestyles (NASTAL), young people aged 16 to 24 prefer to learn about sex from trusted adults, such as school staff, parents and health professionals, but the reality is that they often receive information from other, less reliable sources, such as peers and the media.[2] As a school counsellor living and working in Wales, I am supported in my approach to working with sex and reproductive health by Welsh Government's Period Dignity Strategic Action Plan, which is designed to 'end the stigma and shame associated with periods',[3] as well as the Welsh Relationships and Sexuality Education (RSE) Curriculum.[4] The new mandatory RSE Code has come a long way from my experience of RSE, as a secondary school pupil in the 1990s. It is designed to support schools in providing accurate and age-appropriate information to all pupils aged three to 16, on issues relating to three main strands: relationships and identity, sexual health and wellbeing (to include reproductive health), and empowerment, safety and respect. Although each school retains autonomy in how they deliver the RSE code, ideally the strands are integrated across subjects, with the aim of normalising conversations around these issues, and ensuring that all genders have access to the same information. It's early days for the new curriculum and what it means for the adults delivering it, and the young people experiencing a very new approach to RSE, but it offers a framework of legislative support which enables us to offer up these conversations more confidently in sessions with school-aged clients.

As counsellors, we are in a position, as trusted adults, to engage young clients in conversations about sex, and not shame them for their lack of knowledge or for wanting to know more. While we are not sex educators or medical professionals, we can ensure that we have accurate information and resources to signpost clients, and help them to access these in the safety of sessions if they want or need to. I have information available on the opening hours, contact details and services offered by the local sexual health clinic, as well as a collection of 'go to' websites to explore clients' questions relating to sex, relationships and reproductive health, as part of their session. Brook, the sexual health and wellbeing charity, has an excellent website that I often use with clients, as it has a large collection of help topics, advice on sexual health, real-life stories, free CPD training for professionals, and information for young people (www.brook.org.uk).

When Emily, a sixth-form student I was offering counselling to online, asked me if I knew how to use a contraceptive cap, I used the Brook website in the session to screen share an animated short clip on the topic, and we spent the remainder of the session discussing how she felt about the contraceptive choices available to her. In this role, I was not the expert, but I was able to ensure she had access to accurate information, and I could then support her in making an informed decision.





How to talk about sex

As a starting point, I think it's helpful to be honest and curious about our own attitudes to sex and reproductive health; if we feel uneasy and uncomfortable around these topics, our clients will likely pick up on this, and may feel hesitant to bring these issues to sessions. If your young clients aren't talking to you about sex, it's worth reflecting on why this might be. However, if we can find a way of talking about sex and reproductive health in a way that feels comfortable to us, takes into consideration our client's age and stage of development, and the therapeutic alliance feels robust enough for clients to tell us to 'back off and mind your own business' if they want to, then we're good to go. Often, I've found that conversations will naturally develop around sex if, in building the therapeutic alliance, I talk with young people about contemporary television shows, such as *Heartstopper*[5] and *Sex Education*.[6] For readers who aren't aware of these shows, *Heartstopper* is a Netflix series, based on the graphic novels by Alice Oseman, which explores the romantic experiences of a friendship group of queer teenagers. *Sex Education* is also a Netflix series that follows the life of a teenage boy who sets up a sex therapy clinic as a business enterprise in school, with varying degrees of success! Conversations in the counselling room can also develop while working on a timeline, when I might ask about a client's first crush, kiss, sexual experience or, for girls, when they started their periods.

It was while working on a timeline with a Year 6 client that I asked whether any of the girls in her class had started their periods yet. She opened up to tell me what it was like for her being the only girl in her year group that had. She then went back to her timeline and proudly drew on a red diamond to mark this important milestone.

Niamh, a Year 11 student, told me in her fourth session how lonely and frustrated she felt because most of her friends were dating, and she wasn't. When we explored this, she explained that she didn't feel emotionally ready to be sexually intimate with another person, but she often felt 'horny', and wished she was a boy because then she could just 'have a w*nk', and let some of those feelings out. During that session, we discussed her feelings around the differences between male and female masturbation, and explored the empowering experience of a female character in *Sex Education* who 'discovered w*nking'. Niamh was able to accept that how she felt was completely normal, and the following session she came back to excitedly tell me that she had experienced her first orgasm, safe in the knowledge that I wouldn't think she was 'weird' or 'gross'.

...it's helpful to be honest and curious about our own attitudes to sex and reproductive health; if we feel uneasy and uncomfortable around these topics, our clients will likely pick up on this

I like talking about sex and reproductive health, it's interesting to me. I think there's a good chance that my clients are bringing these issues to our sessions because they can see this, and because, more importantly, I'm asking about it. I'm not saying that we all suddenly need to pretend that we're equally comfortable in talking about things if we're not, but young people are unlikely to bring certain issues into the counselling room unless we give them permission to do so, and if we're not doing that, we're missing out on a rich line of enquiry about an important part of their emerging identity. As trusted adults, we can be important allies for young people as they navigate the physical changes and sexual awakening of adolescence; and we can do this best by talking and listening with confidence. ■

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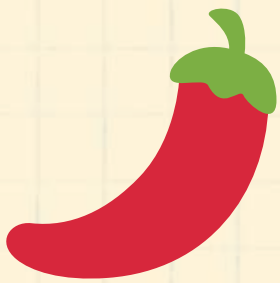

Hiding and being found

Emma Loker suggests that hide-and-seek is a powerful resource in the counselling room which illustrates a child's early attachments and offers opportunities for reparation

'Where are you?' followed by, 'There you are!' is a common interaction between caregivers and their children that starts at an early age. Peekaboo is one of the earliest forms of this – we've all seen it, a caregiver covering their eyes before revealing their face and playfully exclaiming, 'Peekaboo!', to be met by pure delight from the infant.[1] In peekaboo, children can test out their unity with their caregiver in a form of mirrored attunement.[2] To begin with, their conceptualisation is that their caregiver is part of them; but as they develop, they begin to see themselves as separate, and this is when the game we know so well – hide-and-seek – typically emerges.[3]

We expect hide-and-seek to be a natural part of children's play, and many parents introduce the game themselves. Yet, counsellors and psychotherapists repeatedly report clients inviting them to play hide-and-seek in the therapy room. This appears consistent, regardless of the client's age or the precise therapeutic intervention being used.[3] As a newly qualified child and adolescent psychotherapeutic counsellor, who has been practising for just under two years, I have been amazed by how often my child clients request to play versions of hide-and-seek in the therapy room. This can include burying figures in the sand, hiding objects in the room, or physically hiding their bodies. Some clients continue to hide on the journey to and from the counselling room, hiding behind every doorway, before jumping out with a look of excitement as I approach. The urge many clients have to play hide-and-seek piqued my curiosity about what this game may mean for the children who engage in it. And, considering the nature of hide-and-seek, with our clients looking to be found, I wondered how this childhood game could perhaps shed light on our clients' early attachment experiences.

Hide-and-seek and attachment

Separation and reunion play an important role in a child's attachment. Ainsworth's Strange Situation procedure demonstrated how children respond differently to separation from, and reunion with, their caregiver, based on their attachment bond.[4]

Due to the disappearance/separation and appearance/reunion that occurs in hide-and-seek, researchers suggest that this game may serve an important function in developing a child's attachment style, as they learn whether their caregiver will be responsive, empathic and available.[3] This could suggest that hide-and-seek means drastically different things for different children, depending on their early attachment experiences, which is supported by much of the research.[5] For one child, hide-and-seek may help them gain mastery over their anxieties around separation, or better understand previous difficult experiences. While for another, it could relate more to object constancy, helping them develop an understanding that relationships continue, even when you separate from one another.

To understand the potential link between hide-and-seek and attachment more fully, I examined each attachment style in turn. When children play peekaboo, they treat their caregiver like a mirror and look for a sensitive response from them. A child with a severely disruptive early attachment, such as those with a disorganised attachment style, may have only been exposed to, what we might think of as, a broken mirror – meaning their caregiver hasn't responded to them in a sensitive or timely way, perhaps berating them for crying or ignoring them altogether. These children may use hide-and-seek as a way to seek protection from the vulnerability of being face to face with the counsellor, which could feel like a re-enactment of their earlier experiences. Hide-and-seek may also serve the purpose of creating a safe space to dissociate, a coping strategy many children with disorganised attachment styles use when they become overwhelmed.[11] A child with a disorganised attachment style may choose to seek more than hide, as this could give them a different perspective, and perhaps a deeper understanding of their early experiences through metaphorically playing the role of their caregiver.

> ...hide-and-seek means drastically different things for different children, depending on their early attachment experiences

Taking the position of seeker might be particularly beneficial for children who have experienced abuse or neglect, as these children may have felt powerless in their early attachment experiences, and the seeker position gives them the chance to feel more in control.[6]

For a child with an avoidant attachment style who fears being emotionally vulnerable, hide-and-seek may offer a chance for them to experiment with experiencing those intense feelings in a safe space. Those who have an intense fear of others overstepping their boundaries might gravitate towards hide-and-seek as they find safety in the protection of being in a hiding place, as this may make them feel less vulnerable and exposed. They might hide themselves in corners, wrapped in blankets or coats, creating a hiding spot that feels safe and enclosed.

The central meaning of hide-and-seek for anxiously attached children, who fear separation and often cling to their caregiver, may be as a self-other matrix, to help

them identify themselves as separate and independent from their caregiver. This allows them to test where they end and the other person begins, so that over time, they learn that separation can be manageable. Furthermore, for anxiously attached children, and in fact, all children with insecure attachment experiences, hide-and-seek may offer an opportunity to build a more secure relationship with us by metaphorically asking, 'Will you leave me too?' In this way, hide-and-seek might serve a reparative function, allowing children to develop new, healthier models of relationships.

Understanding a child's hiding behaviours

We can begin to understand how to support our clients by paying close attention to the behaviours they demonstrate during hide-and-seek. Securely attached children tend to only introduce hide-and-seek when a real-life separation, such as a half-term break or absence, is approaching or has occurred; while, in contrast, insecurely attached children are more likely to introduce the game more often.[6] It's easy to become frustrated when your client repeatedly plays hide-and-seek; yet, insecurely attached clients may use the game as a way of feeling safe in the room, by testing out whether reunion will consistently occur, and whether we can be relied upon.

Children with an avoidant attachment style show no visible signs of distress when their caregiver leaves them, and avoid their caregivers when they return.[4] It therefore makes sense that, when playing hide-and-seek in the therapy room, these children may not help us to find them, and may not be delighted when we do. In fact, avoidantly attached children may not hide themselves at all. Research suggests that they may be more inclined to hide objects instead of themselves, as this gives them more emotional distance, a behaviour characteristic of their attachment style.[7]

Anxiously attached children show high levels of distress when their caregiver leaves them, and try to re-establish a connection quickly when they return, while also displaying anger.[4] The thought of not being found is extremely anxiety-provoking, so they need to re-establish connection by choosing obvious hiding spots, or giving us pointers about where they are. If hide-and-seek manifests as burying objects in the sand, an anxiously attached child might leave a mound or trail, showing us the way. Choosing an obvious hiding place or offering clues guarantees reunion, which may soothe their anxieties around separation.

A child with a disorganised attachment style often needs to be in control, as the only alternative to feeling powerless. In hide-and-seek, this may manifest as the child trying to trick us, scuffling around in one place, only to quietly sneak off and hide somewhere else.

Understanding a child's being found behaviours

According to the research, children don't only show different hiding behaviours, they also respond differently to being found.[3] If we consider the views about self and others some of our clients may hold, their negative response to being found may not be altogether surprising. For example, those with a disorganised attachment style tend to have a negative view of themselves and lower self-esteem.[8] They also tend to have an intense desire for intimate relationships, but have built defences to prevent people from getting too close.[9] This self-view and way of relating to others may not sit well alongside the experience of being found. What's more, children with a disorganised attachment style often have traumatising early attachment experiences. For them, being found may be linked with a sense of being 'found out', exposed, or shamed which may make it a risky and frightening experience.

> ...hide-and-seek might serve a reparative function, allowing children to develop new, healthier models of relationships

For anxiously attached children who fear separation, the process of fully separating from us may be too difficult to manage. Instead of waiting to be found, they may invite us into their hiding spaces with them, or continually communicate with us while they are hiding and we are seeking them. When we do reunite, these children will likely show joy, perhaps relief, and may want to repeat the experience again and again.

In contrast, an avoidantly attached child who fears being vulnerable may employ various saboteur behaviours, such as hiding multiple objects so we can't find the one we're looking for, or not hiding anything at all, and laughing when they trick us.[10] While feeling like we're continually failing can be difficult, it holds a valuable lesson about the child, and could communicate their paradoxical feelings of wanting connection, but not wanting to feel intruded upon or vulnerable. It's as if they are saying, 'I want you to find me, but I'm not sure I can manage being found.'

Hide-and-seek as a therapeutic intervention

Understanding the nuances of our clients' behaviour during hide-and-seek can help us feel more confident in how we approach the game. Suppose your client needs to be in control and tricks you into looking in the wrong places, you can deduce that they have felt powerless for significant periods of their life, and use this understanding to gradually help the child to feel more powerful, and overcome the need for constant control. If, on the other hand, your client does not delight in being found or chooses to hide objects instead of themselves, this may help you to understand the child's fear around relating to

others. For these children, interventions around feeling safe are vital. Finally, if the child uses clues and obvious hiding places, it may indicate that they have an overwhelming need to be found. For them, hide-and-seek is so incredibly anxiety-provoking that they want to help you find them to make sure that you do, which provides reassurance that reunion will always follow separation. We can support these children by continually showing up for them, and demonstrating that we will always find them, no matter what; and illustrating that, in healthy relationships, reunion does follow separation.

The hide-and-seek behaviours our clients exhibit offer us a window into their early attachment experiences, which we can use to inform our interventions and responses within the game, and in the work. Thought about like this, the game becomes powerful. It deepens our understanding of each client and gives us a chance to do things differently for them. Through hide-and-seek, our clients give us a beautiful opportunity to demonstrate safety within a relationship, and show them that they are worthy of being found. ■

Emma Loker is a newly qualified integrative child and adolescent psychotherapeutic counsellor who works with children and young people in Cambridgeshire. She has previously worked in a hospice, as well as primary and special education settings.

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Columnists

Our three regular columnists talk about what's happening now in training, in counselling and in supervision

In training: Large cohorts

Sue Kegerreis

The psychodynamic counselling course I run has grown enormously, causing a shift in dynamics, both within the group and with staff. More trainees coming forward is welcome, but larger groups bring new challenges, generating a complex mixture of gains and losses. Large cohorts offer richer diversity in terms of age, class, race, ethnicity, experience and personality type. Students might range in age from 20s to 70s, with all that this implies in terms of life experience and outlook. Each student finds people they connect with easily, and others who need to be reached across significant differences. They learn enormous amounts from one another, alongside usefully negotiating tensions. Subgroups develop which offer mutual support, with the uniquely deep and honest friendships engendered by this kind of course. Minority students are likely to feel less isolated. Mixing in whole-group events, trainees still meet the wider cohort, but everyone is more likely to find a place to 'fit'.

However, it is easier to deliberately hide, or feel invisible, in a larger group. Staff cannot know everyone with the depth possible in a smaller group. Absencesfeel different too. When first-year student Samira missed a week's seminars, she could imagine that her absence was unimportant; while in a smaller group, each student knows that any absence is keenly felt. This can mean that students more easily feel overlooked or forgotten; but for some, it offers more freedom to carve their own way through the course, without the same feeling of responsibility for the survival of the group.

The 'pecking order' is less evident in a larger group, and less confident or able students may not feel as exposed. For example, when Johann felt bad about how much he was struggling with new terminology, it was comforting for him to realise that many of his peers were having the same experience. He became much more at ease and could take up a different role in the group.

In relation to staff, large groups provide ample scope for splitting and projection. As the group has less experience of feeling jointly held by the whole staff team, individual tutors are more the focus. Small group leaders become more readily idealised or scapegoated, as they are looked to for the creation of a 'home' within the larger organisation. As course director, I can be seen as a somewhat feared 'headmistress' type figure, for example if students have a difficulty beyond a tutor's remit, or face placement problems and I need to intervene. The greater distance from the tutors makes space for more fantasy, creating more of a 'them and us' dynamic. However, it can also generate a more independent spirit in the students as they rely more on one another, and use each other and staff differently.

Sue Kegerreis is course director of MA Psychodynamic Counselling at the University of Essex. Both a child/adolescent and adult psychotherapist, she has worked in a range of public settings and privately.

In counselling: Too much choice

Linda-Jayne Elliott

There is an idea that more is better – if we have more to choose from, we can make the best decision. But sometimes it can be too much, too confusing, too overwhelming, and the importance of making the right decision can become immobilising, so that no choice is made. Counselling rooms can be intimidating places, particularly in the initial sessions, when children are presented with an array of choices. Meeting a new person, visiting a new room and managing expectations can heighten emotion, which makes decision making even more difficult, so asking young clients to make any choices in a first session may be setting them an impossible task.

In client-led counselling, young people have the freedom to make decisions and grow their autonomy. However, choice may not be beneficial for everyone, and rather than asking, 'What do you want to do?', it might be better, initially, to take the lead ourself to reduce anxiety, and ensure the young person feels comfortable in the space. Some clients may want to bring something from home to act as a transitional object for the first few sessions until they feel more comfortable. Other children may prefer to create a routine in the counselling room, which they stick to each week. Having the knowledge about what will happen, by eliminating the need for decision making, empowers some young people, and reduces feelings of overwhelm or anxiety. With clients who maintain a routine, I have sometimes felt stifled by the repetitiveness. But on reflection,

Once the misconception of 'just' [in just listening] has been identified, listening skills are often strengthened
– Elizabeth Holt

I can see that the clients have created a safe space with predictability where decisions don't have to be made.

In the counselling room, when I see a child who is not rushing to pick up an activity, or one that seems unable to make a decision, I take a step back and ask, 'What is going on for this child? Are they assessing the new environment and taking their time to make a calm, collected decision? Or, are they overwhelmed or anxious about the amount of choice being offered to them?'. This may be the first time that they have been given the responsibility of decision making, as most of the time decisions are made by adults, particularly for younger clients.

I fall into the trap of offering too much choice, in an effort to offer something for everyone. I have a suitcase full of resources, which is continually growing. Trying to provide everything a young person might need in the counselling room is a big responsibility, and can cause me to feel overwhelmed. Let's take the pressure off ourselves, as well as our clients, and take the time to develop confidence in making *less* choices, which will empower them in session and long after they leave us.

Linda-Jayne Elliott is a BACP accredited counsellor and clinical supervisor who manages a school-based counselling service in Northern Ireland, and develops parent and young people workshops.

In supervision: Just listening
Elizabeth Holt

A theme I have noticed in supervision sessions recently has been the concept of 'just listening'. I have heard supervisees, especially those in training or early in their therapy careers, reflecting on how they were 'just listening', while discussing client work, and exploring the dynamics or interventions in the counselling space. I am always curious about what it is they mean when they make this statement – particularly the use of the word 'just'. Carl Rogers described active listening in therapeutic relationships as a special kind of listening that 'is one of the most potent forces for change'.[1] Despite this, therapists continue to undermine their skills by confusing active listening – which involves engaging with another person's experience using empathy and understanding – with simply hearing. Good therapy, like good supervision, relies on the presence of the therapist and their responsiveness to the person (or people) in front of them. The modern world, while more connected than ever through media and technology, reports a loneliness epidemic, leading me to recall a favoured Roxy Music lyric, 'Loneliness is a crowded room…all together all alone'.[2] Can there truly be such a thing as 'just listening' in the context of the therapeutic relationship, when listening is so valuable, and being seen and heard is seemingly so rare for so many?

During exploration of the therapist's sense that they were 'just listening', which is often followed by a disclaimer of how they felt that they didn't really 'do' anything, is my detection of what I refer to as a counsellor or psychotherapist's 'self-gaslighting'. Here, a practitioner will claim that they had no hand in the positive outcome because no intervention was offered on this occasion, and they claim to have simply listened to their client. However, listening is itself a skill that not everyone possesses. It is also a verb and therefore an action. Despite active listening often being one of the first skills covered in a foundational counselling training programme, professionals continue to undermine its value.

Exploring the theme of what it means to listen, and how supervisees can use and embrace their skills fully in their client work, has led to rich discussions and learning. Once the misconception of 'just' has been identified, listening skills are often strengthened, and therapists develop a greater understanding of what it means to lean into the foundational skill of being a fully present counsellor, when all that is required is the capacity to listen (without the 'just'). This is often the thing that our client requires the most.

Elizabeth Holt is a BACP accredited counsellor, clinical supervisor, EMDR psychotherapist and mindfulness teacher working in private practice. She specialises in supervision within educational settings and is completing a doctorate in psychological trauma at the University of Chester.

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Difficult parent or traumatised parent?

In a co-authored article by members of the Parent Carer Trauma Working Group, **Joanna Griffin, Ellie Finch, Megan Yakeley, Naomi Bonger** and **Poppy Villierezz** draw on their combined personal, clinical and academic experience to raise awareness of trauma in SEND parent carers

The emotional wellbeing of parents of children with special education needs and disabilities (SEND) can often be overlooked by the professionals working with their children, yet they are at greater risk of poorer mental and physical health than other parents.[1,2] They may not only be under considerable emotional distress, but they may also be experiencing trauma, which can sometimes lead to them being labelled as 'difficult'. This lack of awareness means that many do not receive timely and appropriate support. These parents must suddenly navigate new worlds of disability, neurodiversity or medical complexity, and the educational, health, or social care systems around them, which can both hinder and help the parental burden. Parents report being blamed[3] or not being believed, as well as experiencing stigma and discrimination. Some parents do not recognise themselves as 'carers', so may miss out on support that is available to them, such as a carers' needs assessment. In counselling professions, we are aware of the need for sensitive support to help with the re-orientation required for parent carers to understand their new reality,[4] but many professionals in different disciplines have less understanding. With this in mind, the Parent Carer Trauma Working Group was set up with the aim of raising awareness of trauma in SEND parent carers. This group brought together professionals and parent carers, to draw on combined lived, clinical and academic experience to consider trauma in parent carers. We believe it is not always recognised, and its complexity means appropriate referrals for support are not always made. Parent carers have said they meet with professionals who are unaware of the social model of disability,[5] and who remain with the predominantly negative narrative around disability that still exists in our society.

Understanding trauma in parent carers

The working group discussed different types of trauma, including 'big T' events such as a difficult birth, unexpected diagnosis, distressing medical intervention; and 'little t' events which are frequent smaller events which together create chronic, unavoidable and inescapable emotional stress. Examples of the latter include the isolation of travelling a different path to other parents, the strain of coping with concerning behaviour, the endless battle for support, and the despair of feeling trapped in an overwhelming situation. In these examples, there is often no end point, no safe space, no chance of 'post trauma' work – rather, it can form an ongoing pattern of accumulating traumas impacting all areas of a parent's life. Our society's fragmented medical systems mean SEND parent carers can be required to repeat their medical history, and with it their embedded trauma, every time they have an appointment, as it will often be with a new clinician. Or a SEND parent carer can know there is something different about their child but not be believed, or appointments take so long that the child's challenges intensify.

The child's developmental trajectory means the traumas continue to accumulate as they fail to reach milestones at the same rate as their peers. This can exacerbate the SEND parent carers' isolation, often made worse by other parents who don't know what to say so avoid saying anything. It can be incredibly painful for a SEND parent carer of a child with a life-limiting condition to watch their child become aware of their own imminent mortality, or witness a neurodivergent child struggle in a neurotypical world. A traumatic birth experience can be re-triggered if subsequent appointments for the child occur in the same building. A child's condition or disability also changes as they grow: some conditions have repeated occurrences so that the parent carer remains in a constant state of justifiable hypervigilance. Witnessing your child in significant pain or distress and being unable to help is to experience indescribable suffering. All of these are real examples of the day-to-day traumas experienced by SEND parent carers.

They have few places to turn

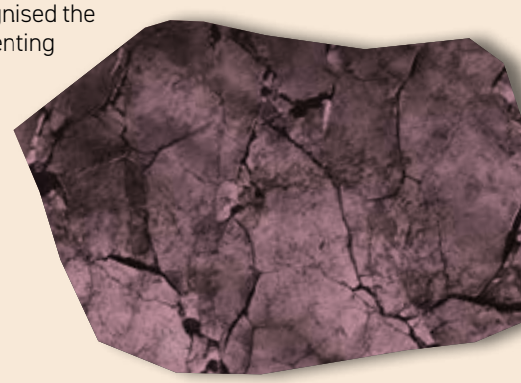
However, professionals from all disciplines can make a difference to the experience of SEND parent carers. By recognising the potential for trauma and understanding that it may not look as they expect, professionals can avoid adding to the trauma burden. By resourcing and taking care of themselves, those working in this field can build resilience, and by encouraging self-compassion in parents, they can support them to tap into their own resources to heal and meet the challenges they face. Finally, by acknowledging overwhelming situations in parents' lives, showing understanding and being non-judgmental and non-pathologising, professionals have the opportunity to transform a lonely and disorientating path into one in which parents feel empowered and supported.

National Institute for Health and Care Excellence (NICE) guidelines for post-traumatic stress disorder (PTSD) were included in the discussions of the Working Group. However, it was recognised that for this group, trauma may not be 'post', as it can be continuous. Ellie Finch suggests it could more accurately be described as past present and predicted traumatic stress disorder (PPPTSD).[6] This term does not suggest something pathological that requires a new label, rather it brings together personal and professional experience to create a more nuanced description of experience.

By recognising the potential for trauma and understanding that it may not look as they expect, professionals can avoid adding to the trauma burden

We recognise that NICE guidelines for PTSD include therapies such as trauma-focused cognitive behaviour therapy (CBT) and eye movement desensitisation and reprocessing (EMDR), that have a place in the support offered to SEND parent carers, and there is a recognition of the long-term need for such support. We know that inadequate support can lead parent carers into survival mode, causing overwhelm and social withdrawal.[7] Some parent carers have reported difficulties accessing support, including inflexibility of appointments offered, being discharged from therapy when they miss a session due to their child's alternative needs, burdensome homework, and professionals' lack of understanding of parent carer context.[8] Offering choice and agency to parent carers on the type of support they receive, and when they receive it, is essential.

SEND parent carers have also found support through peer groups and moderated online communities. Some report feeling empowered through gaining knowledge about their child's condition, their rights and the healthcare systems, although others report this to add to their sense of overwhelm. Promoting parents' self-compassion and having spaces for self-reflection is key, and the Working Group felt greater access to long-term talking therapies, as well as the possibility of returning to the same therapy over time, was valuable. In addition, the group recognised the benefits of therapeutic parenting support to help manage unique challenges, and the role of Child in Need procedures where the Parent Carer Assessment can address specific needs of the parents within the framework of caring for the child.



Reflective activity

Think back to an interaction you've had with a SEND parent carer in your own practice, and briefly note the details of the interaction. Drawing on anything you know about their situation, map out three possible challenges that might have been impacting that parent, such as limited sleep or a struggle with services. Underline anything that could have been experienced as traumatic by this parent.

Positives and strengths

Parent carers exhibit remarkable strengths. With the right support, they demonstrate resilience and adaptability. The Positive Gains Scale[9] was developed to assess parental perceptions of positive aspects of raising a child with a disability, and uses statements such as: 'Since having this child I feel I have grown as a person' and 'Raising this child helps put life into perspective'. The Positive Gains Scale is a useful tool for a parent who is ready and able to reframe their thinking and emotional response to their child's distress.

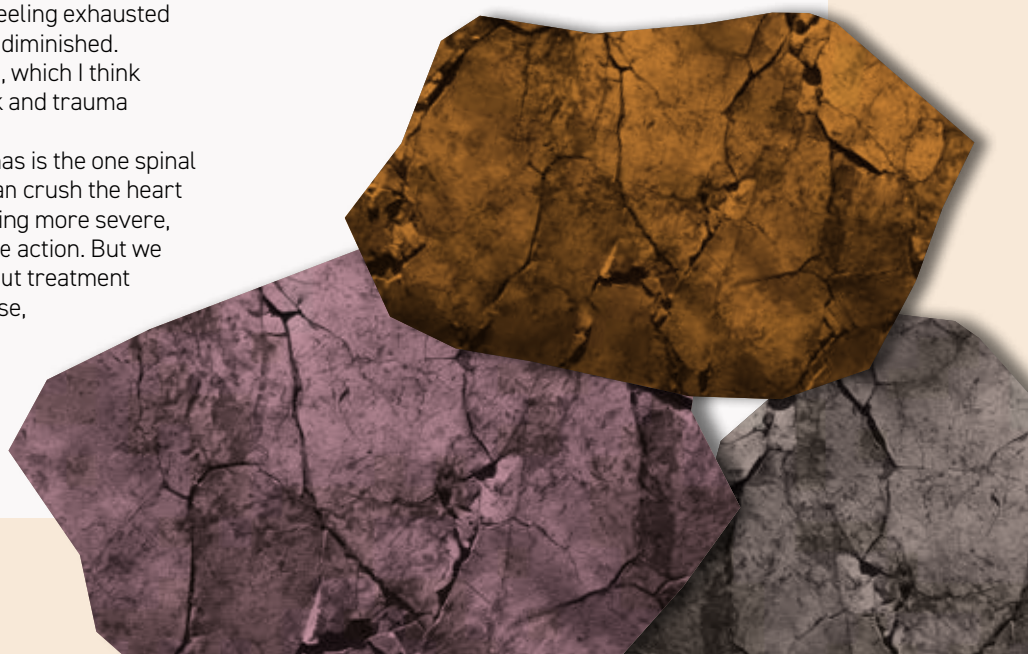
Poppy's story

My seven-year-old son has a rare genetic condition resulting in mobility problems, tube feeding, medical fragilities, neurodivergence and severe anxiety. When he was born, we didn't know that anything was unusual, but soon we began to discover various challenges: he struggled breathing, he had a hole in his heart and scoliosis. While initially we thought these difficulties would be rectified with medical procedures, the sense that he may be disabled began to loom over me quite profoundly. This felt traumatic: the unknowns were scary and I felt isolated as there was an awkwardness in other people, and a resistance to having conversations with me about my son. Whenever I shared my worries, they were brushed off and I was left feeling like I was being neurotic, and yet my gut feeling was that this was a big deal. The sense of not being believed or heard pushed me into a deep sense of separateness and loneliness.

After my son's diagnosis, I felt grief, shock and resistance. I felt ashamed because I felt I should be able to welcome all of my child, and yet I felt extreme dread. This cocktail of overwhelming emotion turned into hypervigilance, and an urgent need to take action: to research every single aspect of his condition in order to reduce the harm and rejection that I felt my child was going to face. I sunk into a deep low, feeling exhausted and numbed out, and my sense of joy diminished. I developed an autoimmune condition, which I think was part of the response to the shock and trauma of this massive event in my life.

I learnt that the scoliosis my son has is the one spinal condition which can kill a child as it can crush the heart and lungs. The curvature was becoming more severe, and I managed to get a hospital to take action. But we were lost in the system and left without treatment for months. I knew it was getting worse, and seeing this threatening condition develop right under my nose, while no action was being taken, was horrifying. The sense of being up against this huge institution and not being heard felt utterly oppressive. I felt tiny in the face of a system that wasn't responding. Eventually, my son had dangerous spinal surgery. The build-up was full of dread and fear that the treatment could paralyse him. In the hospital and in the aftermath at home, witnessing him in extreme pain was one of the most traumatic parts of my journey so far. Not being able to help him when he cried out, the painkillers not being enough, three months of unmanageable pain, not being able to get support or advice from the hospital, and being up all night, every night, had a profound impact on me.

I still manage the ongoing stress of my son's chronic anxiety. We spend hours every morning doing anxiety management. I am hypervigilant because I know that he could spiral into a panic attack at any moment. There's the night-time vomiting which is part of his condition, the endless nights spent awake changing sheets and calming him back to sleep. There's the guilt for not working harder to make the situation better. There's the ongoing sense of separation from family and friends, and the difficulty watching other children freely run about and play while the parents chat, while I have to support my son to find ways to join in. Trauma has been part of my parenting path in big and small ways, some are obvious and others feel unseen.



Support for professionals

In the counselling and therapy profession, we have a well-established model for supervision. Other disciplines do not and may not recognise the impact of working with trauma. Medical professionals are exposed to many traumatic events, yet do not have robust structures for emotional support. Their coping strategies can sometimes be experienced by patients and parent carers as emotional distance, or even as re-traumatising experiences. Training for trauma, recognising vicarious trauma, and seeking supervision or reflective spaces, is vital for all mental health, physical health, and social care providers working with this group.

Recognising vicarious trauma and seeking supervision or reflective spaces is vital for all mental health, physical health and social care providers

Conclusion

SEND parent carers are often an unheard, unrecognised and critically judged group of parents, and the day-to-day reality of their parenting experiences often goes unwitnessed. While NICE guidelines for PTSD offer a starting point, understanding and addressing parent carer trauma requires further research. We do not fully understand the extent and seemingly never-ending nature of their distress. In sharing the work of the Parent Carer Trauma Working Group, our aim is to shine a light on how trauma can manifest in this cohort, particularly the ways in which it might differ from other experiences of trauma, and explore the impact on the parent and wider family. Counsellors and therapists play a crucial role in providing non-judgmental spaces for both parents and children, recognising the emotional responses and overwhelming situations parent carers face, and thereby offering meaningful support. The Working Group aims to raise awareness in the wider professional world, highlighting the importance of long-term therapeutic support for those that need and want it. ■

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Ellie Finch MBACP (Accred) is a parent carer, social worker and children, parent and family counsellor. She specialises in working with families of SEND children and is director of an innovative online therapy practice incorporating creative digital tools. Ellie also provides consultancy and training to professionals and organisations wishing to incorporate these tools into their services: www.elliefinch.co.uk

Dr Megan Yakeley is a child and adolescent psychotherapist and psychotherapeutic counsellor (for adults) specialising in supporting parent carers of autistic and developmentally traumatised children not living with birth families.

Naomi Bonger is an internal family systems (IFS) trained arts therapist and co-founder of Murmuration Community Therapy, an organisation supporting the emotional wellbeing of SEND parents: www.murmuration communitytherapy.com

Poppy Villierezz is a SEND parent who has suffered trauma due to her son's disability and medical fragility. She is co-founder of Murmuration Community Therapy.

Further information about the Parent Carer Trauma Working Group is available here: **www.affinityhub.uk/9/Trauma.html**

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Just listening

Mary Alexander uses poetry to describe the way she applies counselling skills in her role supporting young people in secondary school

You're sitting just across from me, relieved you've reached this place
The trouble you had getting here is etched across your face.
I think the journey has been hard, there's been heartache on the way,
But now you've reached this silent place, there's nothing more to say.
I see from how you're sitting that your body's tense and tight,
Like a rabbit caught in headlights, you're paralysed with fright.
And so, we sit in silence, just the ticking of the clock,
And yes, we'll keep the silence until you want to talk,
So, we sit here waiting, just waiting.

You're sitting just across from me, and still you make no sound.
Your eyes first darting round the room now settle on the ground.
You find the carpet interesting or perhaps it's just your shoe,
Whichever one it seems to me you don't know what to do.
And then at last you lift your head and stare right at the clock,
And without a single cue from me, you slowly start to talk.
Slowly first to check things out, the words seem hard to say,
And then you find momentum and your voice just runs away,
So, I sit here listening, just listening.

You're sitting just across from me, at last you've found your voice.
You know you do not have to talk, you know you have a choice.
But you seem so keen to get it out, to tell me of your shame,
And I will sit here listening, you know I will not blame.
I have no right to judge you or offer my advice,
I'll simply sit and listen and know that will suffice.
Your eyes are filling up with tears, you've had a troubled past,
All that pent up hurt and sadness, the tears now flowing fast.
And I will sit here listening, just listening.

You're sitting just across from me, you have so much to say.
I will not interrupt you, I will not move away.
You say you tried to tell a friend, a friend you thought would care,
But she was far too busy, it really wasn't fair.
Every time you tried to speak, she stopped you with her chatter,
They really didn't seem to care, as if you didn't matter.
Another friend was just as bad, he laughed and said OK,
Absorbed in problems of his own, with nothing good to say.
But I will sit here listening, just listening.

You're sitting just across from me, the tears are getting less.
You wipe your nose and flick your hair and say you are a mess.
I take the chance when you are quiet to check I understood.
I do not pry, I do not lead, I try to sense your mood.
I simply check I've got it right and heard what you have said
And understood its meaning and have not been misled.
It really is important to be with you all the way,
And if I've got it badly wrong you really ought to say,
For I'm listening, really listening.

You're sitting just across from me, I can see you check the clock,
The time is nearly over but you still want to talk.
I need to bring this to a close, I know you'll find it hard,
And once again I notice you putting up your guard.
But you understand my reasons, we talked of this before,
That if you found this helpful you know you could have more.
And then you wipe the single tear that's running down your cheek,
And tell me with emotion that you'll be back next week.
Because I listen, just listen. ■

Mary Alexander was working as a nurse when she completed a counselling skills course at Edinburgh College. She now uses those skills in her role as a specialist support practitioner in a secondary school in Edinburgh.

Why therapy is political

Aleesha Khan urges us to address political dimensions of children's lives in counselling to contribute to a more inclusive and equitable society

I am an integrative and person-centred psychotherapist, and a woman of the global majority, meaning from African, Asian, Middle Eastern, indigenous, or dual-heritage backgrounds. My family's roots lay intermingled across the Middle East and South Asia, now settled in Singapore. On that note, let this introduction be a gentle call to find a comfortable spot, with a drink of your choice, perhaps with a fragrant note, or stirred with a garden spice. As my *nanijoon* (*nani*: grandmother, *joon*: dear) has taught me, 'A good conversation deserves a good cup of tea'.

Children and young people navigate a world influenced by complex encounters with their race, culture, gender and sexuality. Naturally, they engage with multiple systems, including family, school and broader society. During development, they are in an active process of

learning the ways essential aspects of their identity interact relationally to these systems. When children come to us for therapy, our duty is to attend to their primary concerns or conditions, which I believe is further supported when we create an environment that explicitly recognises and respects their ongoing exploration of identity. This practice requires self-inquisition, research practice and inherent values of curiosity and learning.

However, acknowledging this part of the work can sometimes be met with resistance and avoidance. I have experienced others in the field finding the topic of intersectionality and anti-racist practice controversial. I have been told that therapy should not be so political. This article will explore why I believe therapy, like the world we live in, is in fact political. That is not good or bad, but simply the truth that we owe ourselves and our clients. I will draw on my personal and professional experience, and reiterate why my research and experience in trauma recovery have led me to advocate so strongly for actively supporting clients' identities in therapy. This modelling of the environment our clients deserve develops their sense of autonomy as individuals deserving of respect. For the purpose of this article, I will focus on race and culture, but I believe these ideologies apply to all types of marginalisation and systemic oppression.

Why identity matters for young people

Identity is not an abstract theory, it's a tangible, lived experience. Looking at race as an example, growing research in adult participants has indicated a link between cardiovascular reactivity,[1] compromised immunological functioning,[2] and disruptions in sleep patterns[3], and race-related stress. This tells us that there are significant psychological and physiological impacts of racial distress. Similarly, Flores et al.[4] found that adolescents who reported greater racial discrimination reported more post-traumatic stress symptoms which, in turn, were linked to increased drug and alcohol use – an avoidant coping strategy commonly observed in individuals exposed to trauma.

To address these concerns, there have been recent strides in culturally-informed and race-based therapy,[5] gender-focused therapy,[6] and other identity-oriented approaches. This research underscores the pressing demand for creating dedicated spaces within therapeutic settings, where young individuals can openly and authentically explore, discuss and validate their identities.

...our duty is to attend to [children's] primary concerns or conditions, [within] an environment that explicitly recognises and respects their ongoing exploration of identity

The role of the therapist

The therapist's role in embracing children's sense of identity, and potential cultural experiences, is pivotal for effective therapy. Firstly, as therapists, we must remain informed about topics such as race, gender and sexuality. This knowledge allows us to better understand the unique needs of our clients. For instance, delving into resources like Colin Lago's *The Handbook of Transcultural Counselling and Psychotherapy*,[7] with its diverse perspectives from various cultural backgrounds, enriched my understanding.

Furthermore, fostering self-reflection is an ongoing process that helps us address our own biases and prejudices. To illustrate, consider a therapist who realises they have limited exposure to queer individuals in their personal life or media consumption. Engaging with queer perspectives and lived experiences prior to therapy sessions with queer clients could allow the therapist to approach these sessions more empathetically and effectively.

In addition, therapists can use their positions to advocate for policies and practices that promote equity and inclusivity for children and young people. It's crucial to recognise the influence each individual possesses. For example, speaking out against discriminatory practices within an organisation can have a significant impact. Importantly, therapists should acknowledge that marginalised individuals (e.g. global majority, queer) often face more risks when speaking out, compared to those in privileged positions (e.g. white, heterosexual). Embracing these political realities is fundamental to providing effective and equitable therapy for children and young people.

The power of validation

Acknowledging identity-based factors is paramount for various reasons. Firstly, it offers validation and empowerment to young people who must navigate systems where aspects of their lives are inevitably politicised. Consider a situation where a therapist works with a teenager from an underrepresented background. By recognising and discussing the challenges, as well as any disparity in

treatment between the therapist's identity and the client's identity, the therapist validates their experiences, and provides a space for discussion.

Moreover, delving into political realities cultivates resilience and self-awareness. When young people are well-informed about social issues and their own identities, they become better equipped to face life's adversities. For instance, a young person who engages in discussions about cultural identity, openly and honestly gains a deeper understanding of their heritage, enabling them to respond more confidently to cultural biases or misunderstandings.

Addressing the political dimensions of children's lives is vital for therapists as they contribute to the creation of more inclusive and equitable societies. By fostering open dialogues among diverse groups of young individuals, therapists promote empathy and understanding. This approach helps break down societal barriers and actively combats discrimination. In essence, therapists play a crucial role in building bridges between different perspectives, and advocating for a more inclusive world.

Identity work in practice

I am the oldest cousin (and honorary aunt) in my very large family, meaning I have about 15+ younger relatives who I've had the privilege to be a trusted adult to. I am their confidante, their co-conspirator and their bedtime storyteller. Coming from such a diverse family (Egyptian, Kazakh, Singaporean, Iranian, Swiss, British, Pakistani and more) has provided rich encounters with transcultural children and their inner worlds. In my therapeutic practice, I've noticed that children want to talk about their skin colour, their accents, their gender and sexuality, their country's history and, most of all, about who they are inside and how they are treated for their outside.

In my work with young people post-trauma, I have seen how the cultural dynamics within the familial unit often serve as the cornerstone for comprehending their world, and the intricacies of their life experiences. As such, to engage collaboratively on the topic of identity inevitably lends us a deeper access into explorations of self-worth, self-commitment and self-care.

...there exists a notable gap when it comes to addressing issues of identity and cultural competency, particularly among white practitioners

The role of white practitioners

In my time speaking on this topic, I have been grateful to chat with curious and engaged white British practitioners wanting to ask more questions about being culturally-informed therapists, the most common being, 'Where do we start?' and, 'Who can I learn this from?' This tells me two things: that many white British counsellors have an interest in engaging with privilege and oppression, and that a more standardised level of identity-oriented and anti-racist education is missing from their curriculum and training. Within the field of psychotherapy, there exists a notable gap when it comes to addressing issues of identity and cultural competency, particularly among white practitioners. While some training programmes may offer this, there is often a lack of standardisation and regulation. Consequently, some white practitioners may not feel an obligation to engage with these critical topics appropriately. Recognising and addressing this gap is essential for fostering a more inclusive and culturally sensitive therapeutic landscape.

While it's impossible to possess complete and exhaustive knowledge about every identity a client may bring, our aim should be to continuously work towards being equitably respectful and well-informed when engaging with clients of diverse backgrounds. This commitment helps us avoid perpetuating systemic oppression, and ensures that we create an inclusive and equitable therapeutic environment for all.

While white practitioners increasingly engage with topics of marginalisation and oppression, they must approach this with responsibility and cultural humility.[8] Marginalised individuals, particularly women of colour, have long struggled to gain recognition, despite their invaluable insights. To foster a more inclusive dialogue, white practitioners with systemic privilege should actively amplify the voices of marginalised practitioners, allowing them to take the lead and set the course. Rather than receiving monetary profit from leading discussions on marginalisation, which has unfortunately become a concerning trend, it would be helpful for white practitioners to prioritise sharing such opportunities; and spotlighting people from the global majority, queer, disabled, neurodivergent and other systemically marginalised voices, on topics of their own lived experiences. Through genuine collaboration, we can collectively work towards dismantling systemic oppression within our profession, and in the lives of our clients.

Conclusion

I would thus like to double down on my message: therapy is political, because what exists in the world outside our therapy room doesn't shed itself at the door. It is sitting with us in that space, and we owe it our attention. As practitioners who may inevitably carry privileges that our clients do not, it is our duty to look inward at the avoidance and resistance we may feel at engaging with those parts of our own identity. I believe the core values of unconditional positive regard, non-judgment and safety cannot be enacted without an intersectionality-informed effort, without acknowledging our own identity, and without being active in welcoming our clients' identity.

As a person from a collectivist and inclusive culture myself, I know that true community and healing require responsibility and duty. So, I urge us to look towards standardising cultural competency from education to practice, and to remember this is a personal responsibility above all else. In doing so, we work towards a more equitable future for children and young people. ■

Aleesha Khan is an integrative transcultural psychotherapist, whose diverse background fuels her commitment to an anti-oppressive, culturally-sensitive, trauma-informed practice. With a psychology background, she is dedicated to supporting sexual violence survivors, people of the global majority and trauma-affected individuals. Aleesha's pioneering research in Singapore has influenced trauma-sensitive policy, highlighting the importance of identity-conscious approaches in trauma recovery.

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Muddy Waters

Phoebe Johnson discusses confidentiality dilemmas in her work with risky adolescents

As a newly qualified psychotherapist, the idea of confidentiality seemed a simple concept. In training, we are taught the importance of discussing confidentiality with our clients and their parents/caregivers in the assessment session, to ensure the safety of both client and therapist. We say something along the lines of, 'Everything discussed here remains between you and me, unless you disclose something that suggests you, or someone else, is at risk of harm'. As I say, it's a simple concept. Or so I thought.

Throughout my work with adolescents, it has become clear that confidentiality is not black and white, and I have been presented with numerous dilemmas where I have been left asking myself, 'What, when and with whom should I share information?'. Often, the answers to these questions have not presented themselves easily. They've required reflection, inside and outside of the sessions, as well as an examination of my moral and ethical responsibilities, and my gut instincts. When these situations have arisen in my practice, it has felt as though I am having to navigate my way through muddy waters, trying to find a clear answer about how to best handle the information I've been given, in a way that ensures my client's safety, both inside the room, and out.

There are recurring themes whereby the complexities of confidentiality have been highlighted, commonly drugs, sex and self-injury. Working with adolescents, it is highly probable that these themes are going to be brought into the therapeutic space. All come with obvious risk factors, but are often a part of an individual's exploration and development, while growing from child to adult. Through my experience, I have found that the approach to working with these subjects follows a similar pattern: assessing risk, thinking together about safety, and ongoing review of risk throughout the work.

When a client brings risky topics to therapy, the first thing I do is consider the level of risk. For example, with drugs, I consider what drugs are being taken, how often, in what situation and with whom. When we are discussing sex, I think about who is involved, the types of sexual activity being engaged in, whether safe sex is being practised and whether it includes the consent of both parties. When discussing self-injury, I consider what method is being used, the intent, frequency, location on the body, degree of self-harm and hygiene. For all situations, I also consider the young person's age and stage of development, the impact that it is having on their physical and mental health, and the impact that sharing this information would have. I think about and discuss these aspects of risk in session with the adolescents themselves, as well as in supervision, which the young people are aware I attend.

> Holding information, without sharing, may be appropriate at first, but no longer in their best interests as new experiences and information are shared

My aim is to create a space that feels safe enough for my clients to disclose information that might feel risky to share. I think it's incredibly important to be understanding and non-judgmental when hearing about clients engaging in risky behaviours, however, I also want to address the fact that these things do carry a lot of potential risk. My approach is to open the dialogue and model direct and honest conversations, advise on safety and psychoeducation, while trying to avoid lecturing. I want to understand the young person's experience, without making assumptions about their thoughts, feelings and actions; but also engage them in thinking about consequences that they may not have considered, such as the physical and mental impact of drugs, sex and self-injury, and how to take care of themselves in these situations to try to reduce the risk as much as possible.

Over time, situations may change, and it's therefore important to remain tuned in to the level of risk that a client may be facing. Holding information, without sharing, may be appropriate at first, but no longer in their best interests as new experiences and information are shared. It's often concerning to hear about client's risk-taking behaviour. I share my concerns with them as we talk, and remind them of the bounds of confidentiality and my duty of care to keep them safe. In my experience, communicating this from the beginning has meant that if/when I have made the decision that I need to share something with a parent or caregiver, my client has understood why, and it hasn't damaged the therapeutic relationship.

Understanding and working within the boundaries of confidentiality requires reflection, adaptation and good supervision. As well as making the boundaries clear to my clients, when working with young people, it is important that parents/caregivers have a good understanding too. I have updated the information that I give around confidentiality in my contract and assessment sessions to ensure everyone is on the same page when work begins.

As with so many facets of therapy, there is rarely one size fits all, and so the bounds of confidentiality require frequent reflection and consideration. I have no doubt that as I continue to practise, I will be faced with many more instances where I find myself questioning where these boundaries fall. As my clients do their best to navigate the complexities of growing up, experiencing the good, the bad, the ugly and the glorious, I'll try to do the same in navigating these muddy waters alongside them. ■

Phoebe Johnson is a psychotherapist working and living in Kent. She runs a private practice where she works with adolescents and adults.
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Do you have what it takes?

Editor **Jeanine Connor** answers the questions she is frequently asked about being published in this journal

I'm often asked what it takes to be a writer and get your work immortalised in print. I've presented and written previously about my own experience of becoming published in the hope that it helps other budding wordsmiths.[1] Here, I answer the questions I am most frequently asked about how to write for *BACP CYPF*. As always, I speak from my own perspective, in this instance as editor of this journal, and it should not be assumed that editors of other publications would give the same answers as me. If it's on your 'to do' list to be published, reading these FAQs might be a good place to start.

Q. Can anyone get their work published in *BACP CYPF*?

A. Anyone can make a proposal, but there is no guarantee that it will be accepted for publication. To be published in this journal, you need to have both a good idea and a good grasp of written English, and not everyone has those skills. You also need to be familiar with using tracked changes in Word.

Q. How do I make a proposal?

A. You can contact me with your idea for an article at **cypf.editorial@bacp.co.uk**. You should outline the main themes you would like to discuss, and explain how this would appeal to our specific readership of counsellors and psychotherapists working with children, young people and families. Your idea should be original, interesting, informative and (ideally) supported by evidence.

Q. I've already written an article, can I just send it to you?

A. No. I don't accept unsolicited articles and as a freelance editor, I don't have the time to read and provide feedback on work that I haven't commissioned. Please send a proposal and we can take it from there.

...I am particularly interested in hearing from people who would like to write about themes to do with working with older adolescents and with families

Q. If my article isn't well-written, will you make it better?

A. It is important to maintain a high standard of content in *BACP CYPF* journal. I can offer suggestions about how your work could be improved, and I will carry out surface editing to make sure it adheres to BACP house style. However, it is important that all published content is the work of the author named, and so the author must be the one to write it. If you don't think it's well-written, it probably isn't of a good enough standard for publication.

Q. What is the editor's job?

A. It might sound obvious, but as the editor, I edit and as the writer, you write. I think of the relationship between editor and writer in a similar way to that between counsellor and supervisor. The counsellor is responsible for doing the work, the supervisor's role is to make sure the work is being carried out safely, and in accordance with professional standards, and they offer guidance and support from their position of experience. As editor, I make sure that all submissions meet the requirements of BACP's author guidelines in terms of content and consent,[2] and I offer comments and suggestions about how they could be improved.

Q. Why do you need consent?

A. It is a BACP requirement that you provide written evidence of consent and/or permission to share anything that could be recognisable by anyone who reads your article. This includes clients and ex-clients, their family, your family, friends, colleagues and organisations. Written consent is required if you are referencing events or conversations, no matter what context they took place in. There are absolutely no exceptions to this rule, and I will not read any submissions without making sure that the necessary consent is in place.

Q. Can I write about my client work?
A. You can write about the themes of your work, but you cannot write anything about clients that could be identifiable by them or someone who knows them, without their written consent. For further guidance about how to write about client work without breaching confidentiality, see *I once worked with a girl who...*[3]

Q. How much should I write?
A. Once your proposal has been accepted, I will let you know the requirements in terms of word count and timescales. Articles in this journal range from 500 words for a column piece to 2,500 words for a featured article.

Q. What if I don't have enough to write about or I can't meet the deadline?
A. It is important to let me know as soon as possible if you are unable to meet the brief as content for the journals is planned many months ahead of publication. The more notice I have, the more chance I have of commissioning someone else to write an article to fill the space that will have been reserved for you.

Q. I've never written anything before, how do I know if I'm good enough?
A. You can access back issues of this journal on the BACP website to get a feel of style and content. I would suggest asking someone you know to read something you've written to provide honest feedback about the style and content, what you have done well and what could be improved.

Q. Where do I start?
A. I would suggest starting small. You could submit a letter in response to an article you have read in the journal or offer to write a book review. I commission divisional members to read newly published books, and write personal critiques of what they liked and didn't like about them. Once I have allocated a book to a reviewer, I send them a copy of the book, which they get to keep. Writing letters or reviews is good practice for meeting the brief, writing to word count and meeting deadlines, and gives new writers a sense of the editing process.

Q. What should I write about?
A. It's always a good idea to write about what you know well and what you feel passionately about. Maybe there's a theme that keeps coming up in your work, or maybe you have a particular area of experience or specialism that you would like to share with other readers. Currently, I am particularly interested in hearing from people who would like to write about themes to do with working with older adolescents and with families.

Q. Once I've sent in an article, how soon will it be published?
A. I will let you know the issue that your article is scheduled to be included in at the time of commissioning, although occasionally articles are held back because they are not ready or because there isn't space. It is also important to note that the article you send in will be your first draft and will require more work, sometimes lots more work, to get it ready for publication.

Q. I've sent you my finished article, why are you calling it a first draft?
A. It is important to make your article as good as you can before you send it to me for editing. The editing process is a joint endeavour which will require commitment from you to respond to my comments, queries and suggestions in a timely way. We will work together to get it ready for publication according to the production schedule.

Q. Who else will read my article prior to publication?
A. I work remotely from home as a freelance editor for a small number of hours a week. Once the editing process is complete and we are both happy with the piece, I send it for proofreading and will let you know if there are any queries.

Q. Am I responsible for the design?
A. No, that's my job. I write the title and a few words to introduce your article. I design the layout and visuals and work with a designer to produce them. I share a PDF of the finished design with each author for checking before we go to print.

Q. How much will I get paid?
A. There is no payment for articles published in this journal. ■

Jeanine Connor is a psychodynamic psychotherapist and editor of this journal. She is the author of *Stop F*cking Nodding and Other Things 16 Year Olds Say in Therapy* (PCCS Books, 2022) and *Reflective Practice in Child and Adolescent Psychotherapy: listening to young people* (Routledge, 2020).

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1 Connor J. Do you have a book in you? Private Practice 2022; December: 12–14. www.bacp.co.uk/bacp-journals/private-practice/december-2022/articles/do-you-have-a-book-in-you/
2 British Association for Counselling and Psychotherapy. Author Guidelines. [Online.] www.bacp.co.uk/bacp-journals/author-guidelines (accessed October 2023).
3 Connor J. I once worked with a girl who...BACP Children, Young People & Families 2022; March: 12–13. www.bacp.co.uk/bacp-journals/bacp-children-young-people-and-families-journal/march-2022/articles/i-once-worked-with-a-girl-who/ (accessed October 2023).

News

A round-up of the latest findings and policy updates affecting children, young people and families

Student mental health

A large-scale student survey, led by a research team from Oxford University, has measured the mental wellbeing of children and young people. Areas of interest included indicators of vulnerability, such as bullying and loneliness, experience of school, access to services and online safety. The Association for Child and Adolescent Mental Health (ACAMH) has published a mini-series of podcasts titled *Insights from the OxWell Student Survey* which explores the key findings. Themes of the series include where young people were most likely to find mental health support, preferences of different groups of young people in terms of access to support, ways that Child and Adolescent Mental Health Services (CAMHS) could be better suited to help young people, and ways in which friends, family and schools can better support young people's mental health.

www.acamh.org/podcasts/networks-of-care-insights-from-oxwell-student-survey

A Mentally Healthier Nation

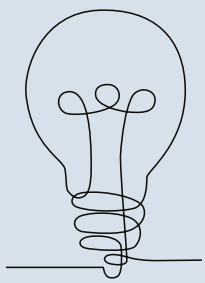
A coalition of more than 30 national organisations has called for action from UK Government to tackle poverty and racial injustice, reform benefits and justice systems, and invest in better and more equitable mental health services. *A Mentally Healthier Nation* report states that children from the poorest families are four times as likely to have a mental health problem by the age of 11 than the wealthiest children, black people are four times more likely to be sectioned under the Mental Health Act than white people, and people with severe mental illness face a 20-year shorter life expectancy than average in the UK. The coalition argues that a fairer society could improve everyone's mental health, and give people with mental illness better life chances. It has called for cross-government action to prevent mental ill health, with focused investment in better services, making *A Mentally Healthier Nation* a comprehensive plan that will benefit us all.

www.centreformentalhealth.org.uk/publications/mentally-healthier-nation

Digital innovation

Northpoint, one of Yorkshire's largest charitable providers of therapeutic services for CYP and their families, has reduced waiting times across the region by 57%, since the introduction of internet-based cognitive behavioural therapy (iCBT) programmes. The service – commissioned in 2019 by Southwest Yorkshire Partnership NHS Foundation Trust, Integrated Care Board health funding in Leeds, local authorities and Leeds school clusters – has seen improvements in accessibility, increased engagement and efficiency in terms of cost savings. To date, over 1,500 children and young people have been supported through the platform across West Yorkshire, with a 91% satisfaction rate. The platform's success has been recognised nationally, with nominations for a digital innovation award at the Children and Young People Now Awards and the Leeds Digital Festival Awards under the Tech4Good category.

www.silvercloudhealth.com/uk/case-studies/how-northpoint-increased-access-to-mental-health-services-for-cyps?utm_source=pr&utm_medium=Press-Media-Digital&utm_campaign=SCH_UK_23_HS_CYP_northpoint-case-study&utm_content=pr-1



Double discrimination

Children's charity Barnardo's commissioned social research agency, Listen Up, to carry out research into how being both black and care-experienced shapes a young person's interactions with the criminal justice system. They carried out in-depth interviews with 22 black care-experienced young people aged 18 to 25, who are currently serving custodial sentences in England. The report highlights inconsistent support, low expectations from professionals, discrimination, racism, exclusion and isolation. Twenty of the 22 young people interviewed, disclosed race or ethnic-based discrimination in care settings, education and/or in the criminal justice system. The report has led to recommendations in the report, including the introduction of a black foster care network, timely access to mental health support, and urgent action from the UK Government to prevent the unnecessary criminalisation of children in care.

www.barnardos.org.uk/news/double-discrimination-barnardos-calls-change-report-highlights-young-black-people-who-have

Sibling sexual behaviour

The Centre of Expertise on Child Sexual Abuse (CSA Centre) is a multi-disciplinary team, funded by the Home Office and hosted by Barnardo's, which works closely with academic institutions, local authorities, health, education, police and the voluntary sector. Its aim is to reduce the impact of child sexual abuse through improved prevention and better response. The Centre produces information about the scale and nature of child sexual abuse, shares research and evidence, and provides training and support to professionals and researchers. A new guide has been created in collaboration with the Lucy Faithfull Foundation to help professionals identify, understand and respond to sibling sexual behaviour. It highlights the importance of reflective practice and self-care, advises on assessment on nature and context of sibling sexual behaviour, and advocates for a whole family response, including support for parents.

www.csacentre.org.uk/documents/sibling-sexual-behaviour-a-summary-guide-to-responding-to-inappropriate-problematic-and-abusive-behaviour

Attempted suicide and self-injury

The Association for Child and Adolescent Mental Health (ACAMH) has published a podcast in which author, and child and adolescent mental health professional, Dr Jocelyn Meza, discusses common elements in treatments for suicide attempts, and self-injury in young people. Themes of the podcast include ways to talk about suicide and self-injury in a non-stigmatising way, global issues, and international differences in the prevalence of suicide and self-injury. Meza also suggests applications and research implications from her co-authored paper.[1]

www.acamh.org/podcasts/common-elements-in-treatments-for-youth-suicide-attempts-and-self-harm

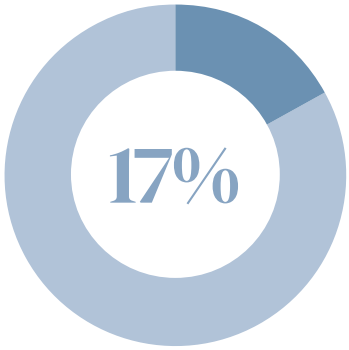
Reference

1 Meza JI, Zullo L, Vargas SM, Ougrin D, Asarnow JR. Practitioner Review: common elements in treatments for youth suicide attempts and self-harm – a practitioner review based on review of treatment elements associated with intervention benefits. Journal of Child Psychology and Psychiatry 2023; 64(10): 1409-1421.

How happy are girls?

A recent poll by Girlguiding UK on happiness in girls and young women in the UK found that just 17% of seven to 21-year-olds reported feeling very happy, compared with 40% in 2009. Almost all (90%) were worried or anxious, compared to 78% in 2018. The number who reported feeling happy with their appearance has fallen from 72% to 59%; while 67% said they sometimes felt ashamed of the way they look, compared to women and girls they see in the media and online. Almost half (44%) said they had received unwanted sexual attention on the way to or from school, while 69% have heard boys at school making sexist comments. Thinking about online harms, 73% of 13 to 21-year-olds have received unwanted sexual images, and 83% reported seeing upsetting content, such as self-harm or suicide. The number of 13 to 21-year-old girls who have received sexist comments online has more than doubled to 57%, compared to 24% in 2018. Girlguiding UK is calling for government action to provide consent training in all UK schools, and age verification controls to prevent children accessing harmful material online.

www.girlguiding.org.uk/about-us/press-releases/girls-attitudes-survey-2023



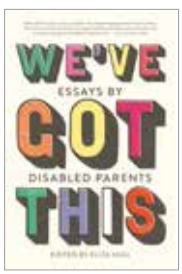
...just 17% of seven to 21-year-olds reported feeling very happy, compared with 40% in 2009

Reviews

Personal critiques of new books for counsellors and psychotherapists working with children, young people and families

We've Got This: essays by disabled parents

Eliza Hull (ed.)
Scribe Publications 2023
ISBN 978-1914484667



This is a book about the 'rebellious act' of being a disabled parent in an ableist society. In 25 essays – some written by the parents themselves, others transcribed from interviews with the editor Eliza Hull – the readers are introduced to the enormous diversity of experiences of disabled parents: those born with disabilities, like spina bifida, achondroplasia, deafness, blindness, neurodivergence, intellectual disability, and others who have become disabled later in life as a result of an accident, medical error or an illness. It presents the voices of parents who chose to have children after identifying as disabled, and those who became parents before. Intersection with other identities – racial, gender and socioeconomic – contributes to the richness of representation, as does the geographical reach – with parents living in different countries in the Western world including Australia, Canada, UK and USA.

Yet, despite the uniqueness of each experience, the essays share themes of the challenges and joys of being a disabled parent. They all present a passionate and eloquent critique of the medical model of disability, and the questioning, judgmental, rigid, discriminatory nature of the ableist model of parenting. Again and again, parents speak of their painful experiences of medical professionals judging their decision to become parents, and of being infantilised, disrespected, shamed and seen as 'less than' by a society that seeks to reproduce the 'norm' (p127).

This is a book, imbued with powerful feelings: anger at society's misconceptions and stigma, and at the lack of support for and representation of disabled parents. As Hull asserts in her introduction, there are 1.7 million disabled parents in the UK, and 4.8 million in the USA, yet they are not represented anywhere. This is a book which also stirs up powerful feelings in the reader; it is difficult not to feel angry when reading about the institutionalisation of people with intellectual disabilities, 'doing time for a crime [they] didn't commit' (p79), or reading about their involuntary sterilisation (p11).

The parents speak not only about their anger, but also about the shame they have internalised in an ableist society. Parenting confronts them with the toxicity of that shame, and the realisation that they have to resolve the shame, and accept and feel comfortable with their disability, before their children can. Yet, this is also a book about joy, love, connection, pride, innovation and adaptability. As Hull reminds us in her eloquent introduction: disabled people are 'masters at problem solving in daily life', and 'parenting demands the same kind of innovation' (p4). Essay after essay presents us with the incredible creativity and resilience with which these parents think 'outside of the box', and overcome the challenges of their disabilities. Blind parents find a way of mixing a formula bottle and pushing a pram, deaf parents know when their baby is crying in the night, wheelchair users learn how to get their baby in and out of the cot and car. Moreover, this resilience is modelled and passed on to the children. As one parent writes, 'through having a disability, I have shown my children that having barriers in your life doesn't mean you have to be held back' (p224).

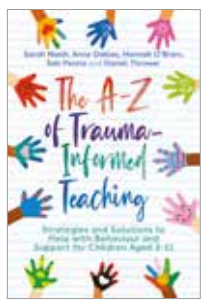
This is a book about the 'many positives of being a disabled parent: seeing compassion, kindness and openness to all differences grow in our children' (p10).

It is a book about hope of building a fairer, more inclusive society, where difference is celebrated and embraced. It is a book about the indomitable human spirit. These stories of resistance and rebellion, courage and creativity touch the soul, empower and inspire.

Lucy Rosenstein is a child and adolescent psychotherapist, with a particular interest in neurodivergence

The A-Z of Trauma-Informed Teaching: strategies and solutions to help with behaviour and support for children aged 3-11

Sarah Naish, Anne Oakley, Hannah O'Brien, Sair Penna and Daniel Thrower
Jessica Kingsley Publishers 2023
ISBN 978-1785923760



As a counsellor working with bereaved children, I was delighted to have the opportunity to review this book, as I was certain that there would be useful practical applications. It is billed as a useful primer for all professionals and caregivers working with children who may have experienced early trauma in their lives. The book is divided into two parts: 'The basics' and 'A-Z of behaviours and challenges with solutions'.

'The basics' starts with an exploration about some of the common challenging behaviours exhibited by some traumatised children, such as regression and a lack of

cause-and-effect thinking, which could provide a useful checklist for the therapist to explore with a child who may have experienced early trauma. It goes on to explore how trauma may impact the developing brain, and explain how disorders such as attention deficit hyperactivity disorder (ADHD) could be linked with early trauma. The book does not offer the latest research on ADHD and trauma-informed practice, however it does offer a whole host of approaches to working with traumatised children in the classroom or counselling room, and suggestions for building positive working relationships with them. These include creating a safe space for children to regulate, and using playfulness as a response to challenging behaviour. Showing empathy and building a strong relationship with the child are emphasised throughout. There is a section on compassion fatigue that I'm sure many who work with children and young people will be able to relate to.

The A-Z section is a comprehensive toolkit of techniques and strategies, and will probably be the book's main selling point. Challenging behaviours are broken down into 'What it looks like', 'Why might it happen', and 'Preventative strategies' to use both before and after the episode. I think counsellors will be able to work with the child to identify the trigger for why a particular behaviour is being exhibited, and work together to ask how the child would like to be responded to in this instance, and establish what help they need. This is a handy guide, perfect for leafing through or looking for a specific challenge using the A-Z.

Overall, I think this book is a useful primer for working with children who may present with challenging behaviours, whether they are trauma-induced or otherwise. It's worthwhile reading part one before accessing the A-Z, even though this will be the most valuable part for time-strapped professionals. The strategies are applicable to the counselling room, and are a useful addition to the therapist's toolkit.

Andy Lawton-Collins is a bereavement counsellor working with children and young people

BACP divisional journals

BACP publishes specialist journals within six other sectors of counselling and psychotherapy practice.

Healthcare Counselling and Psychotherapy Journal

This quarterly journal from BACP Healthcare is relevant to counsellors and psychotherapists working within healthcare settings.

Private Practice

This journal is dedicated to counsellors and psychotherapists working independently, in private practice, or for EAPs or agencies, in paid or voluntary positions.

BACP Workplace

This journal is provided by BACP Workplace and is read widely by those concerned with the emotional and psychological health of people in organisations.

University & College Counselling

This is the journal of BACP Universities & Colleges, and is ideal for all therapists working within higher and further education settings.

Coaching Today

The BACP Coaching journal is suitable for coaches from a range of backgrounds including counselling and pyschotherapy, management or human resources.

Thresholds

This is the quarterly journal of BACP Spirituality, and is relevant to counsellors and psychotherapists involved or interested in spirituality, belief and pastoral care.

These journals are available as part of membership of BACP's divisions or by subscription.

To enquire about joining a BACP division, call 01455 883300. For a free of charge consultation on advertising within these journals, contact Sonal Mistry on 0203 771 7200, or email **sonal.mistry@thinkpublishing.co.uk**

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