BACP

Children, Young People & Families

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For counsellors and psychotherapists
working with young people
December 2024

06

All kinds of minds

Exploring flavours of neurodiversity, and the power of the language we use to describe them

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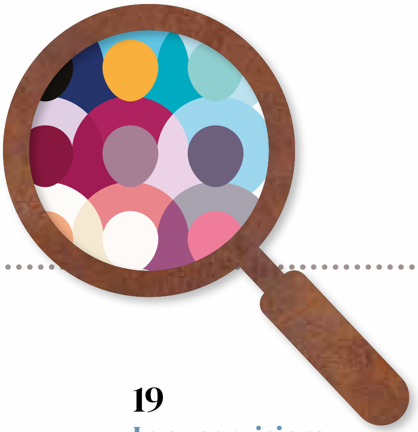
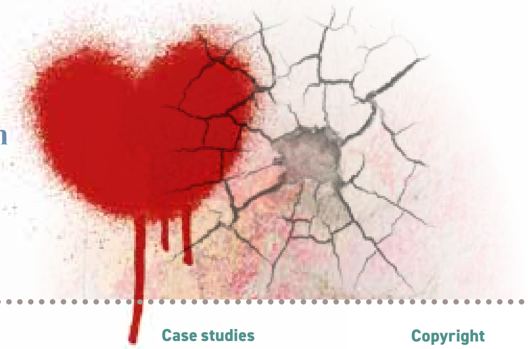


Featured article

Voices



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From the Editor

In practice

'We live in a time of sensitive topics and strong opinions.' My September editorial, which included this quote, resonated with many readers, whose conversations with me have alluded to themes of uncertainty and unrest, linked to events globally and closer to home. It's tempting, at times like this, to feel like battening down the metaphorical hatches, to protect ourselves and our loved ones, or even bury our heads in the proverbial sand. Uncertainty can also lead us into the defence of black and white thinking, as we crave the certainties that appear to be so lacking.

But life is not black and white. Things are seldom all good or all bad. These dichotomies can foster divisions, an 'us and them' mentality and 'othering' whoever is perceived to be different to ourselves. This is rarely helpful, and is often at the root of hate speech, racial riots, and the phobic attitudes towards clients and colleagues in the LGBTQ+ community. As a psychotherapist and supervisor, I often encourage people to sit in, think in and live in 'the grey'; that murky middle where all possibilities exist – both/and, rather than either/or – where we can come together and think together, rather than foster divisions. This is my aim as editor of this journal too. I welcome your feedback, and will continue to aspire to a journal that feels diverse and inclusive, which I share more of in the results of this year's **Readers' survey** (p11).

> **...I often encourage people to sit in, think in and live in 'the grey'; that murky middle where all possibilities exist... where we can come together and think together, rather than foster divisions**

With this aim in mind, and in the current social and political context, I'm proud of the thought-provoking articles I've brought together in this issue, which challenge us to think about our attitudes to diversity. Sarah Haywood's featured article invites us to consider the language we use to describe flavours of neurodiversity in **All kinds of minds** (p06). Sarah says that, 'Talk of difference and divergence can feel othering because it automatically marks out a so-called neurodivergent person as the special case, and implies that there is a neutral, 'normal' reference'. David Cook shares how he's **Deeping it** (p15) by exploring existential themes like death and meaninglessness with adolescents, while holding his own midlife existential angst. Stuart Ralph, also talking about his work with adolescents, challenges 'therapeutic purists' to see **The benefits of therapeutic integration** (p27). Elizabeth Holt explores the impact of turbulent relationships with and estrangement from mothers in **Unmothered** (p24). Naomi Angelica Vibrati invites us to challenge our assumptions, examine microaggressions and asks **Are you culturally competent?** (p12). And in a prophetic look towards our BACP CYPF Conference in March 2025, Imogen Nevard advocates for working **With networks in mind** (p20) with children affected by parental mental illness. Booking is open for the conference, which has a theme of 'Systems around the child' (**https://tinyurl.com/mr3r5ds9**). I'll be there in person (presenting as well as networking this time) and, as ever, look forward to meeting members of the division – even though the very word 'division' feels even more uncomfortable to me now than ever.

So, whatever your 'flavour' of gender, sexuality, ethnicity, ability and therapeutic approach, I am certain there is something in this issue to provoke deep thinking during the darkest (in all senses) winter months. I hope too, that whatever your spiritual, religious or family experience, you have something to celebrate, nurture you and look forward to. See you in March – in print or in person! ■

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 an article for consideration, contact me to find out how 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**

Government support for school counselling

Jo attended the Citizens UK national assembly in the run up to the general election. Deputy Leader of the Labour Party Angela Raynor, one of the keynote guest speakers, publicly stated that Labour are fully supportive of funding mental health professionals in every school. BACP Trustee Emma Farrell also attended the in-person event held at the Methodist Church in Westminster, which included a powerful testimonial from a young person who spoke about the benefits of funding school counselling. Following the election, Jo briefed Baroness Claire Tyler on the vital role the children and young people counselling and psychotherapy workforce could contribute to the issues outlined in the Liberal Democrat Party's proposed Schools (Mental Health Professionals) Bill. (**https://tinyurl.com/3mfyu4wt**).

Jo worked with charity TIC+ and Durham Counselling Service to provide anonymised case studies for the briefing paper. It highlights where counselling and Mental Health Support Teams (MHSTs) have worked as part of a stepped care approach to meet local needs. Case studies highlighted the 'missing middle' – children and young people who don't meet the CAMHS threshold but are not suitable for lower intensity interventions.

School counselling in Wales

A review conducted by Cardiff University across 29 schools in Wales found a positive impact on the mental health and wellbeing of children and young people who accessed school counselling. It also found a decrease in referrals to specialist CAMHS. Notably, only a small proportion of children and young people receiving school counselling were referred to specialist CAMHS (2.9% in 2022-2023), which decreased from 3.5% in 2021-2022.

https://tinyurl.com/mr3tzmw2

Working with the Local Government Association

Jo has been strengthening links with the Local Government Association, and delivered a presentation to their national children and young people's mental health working group around the benefits of funding school counselling from a local authority perspective. Jo discussed the local authority-funded one-year pilot model launched in Brighton for Year 9 students across 10 schools in September 2024, as well as the established local authority model in Durham. One of the models BACP is campaigning for is to devolve funding for school and college counselling in England to local authorities, similar to the established model in Wales.

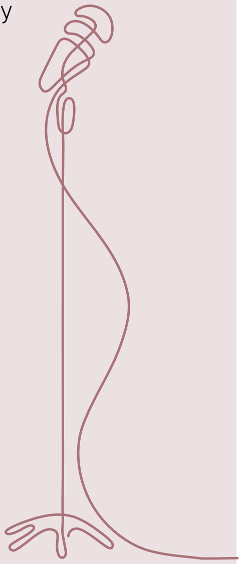
BACP CYPF Conference 2025

The conference theme is 'Systems around the child' with presenters and keynote speakers highlighting the critical role of integrating counselling into the wider system. The agenda will explore the influences on children's development and mental health, emphasising the need for diverse interventions and collaborative ways of working. Delegates will have the opportunity to enhance their skills in connecting the counselling process to the wider psychological wellbeing of the child outside the therapy room.

Workshops will examine collaborative working with education, healthcare, family support, safeguarding and community services. There will be consideration of the challenges and the benefits of collaborative approaches, including how to include adults in the therapeutic process without compromising privacy and confidentiality, and the role of safeguarding in statutory and non-statutory settings.

This is a hybrid event, meaning you can choose to attend in person or online. The conference offers approximately six hours of CPD and an on-demand service enabling delegates to catch up on event recordings for three months following the event, as well as the opportunity to network with peers and colleagues in person and through the event app.

Booking is open: **https://tinyurl.com/mr3r5ds9**



Party Conferences

Jo attended the Liberal Democrats Conference in Brighton where she met with Baroness Claire Tyler to discuss the relaunch of the Schools (Mental Health Professionals) Bill which requires every school to have access to a mental health professional. Claire was keen to discuss how counselling could fill the gap between current interventions, which she called the 'missing middle', and the capacity of the CYP counselling and psychotherapy workforce to take up new roles. Jo helped Claire to understand more about the accredited register held by the Professional Standards Authority, of which BACP is a membership organisation.

Jo also attended the Labour Party Conference, where BACP hosted a fringe event focusing on CYP mental health, chaired by BACP's Vice President Luciana Berger with Lisa Morrison-Coultard, Director of Professional Standards, Policy and Research. The event brought together leading voices from the mental health, youth support and education sectors to discuss Labour's existing commitment to provide mental health professionals in schools and roll out Youth Futures Hubs. They also explored opportunities for wider support, including extending counselling provision to students in FE colleges and addressing mental health as a barrier to young people's employment.

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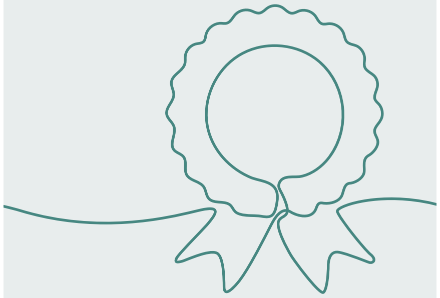
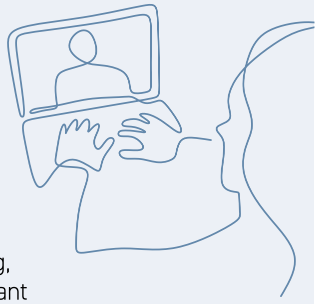


From the Chair



As the holiday season approaches, counsellors working with young people are often faced with additional concerns about the vulnerability that some of them experience during this time. Reduced accessibility to support during holiday periods can add to the stress of young people and their families, especially those in remote or underserved areas. Online counselling and support services can bridge this gap. In recent years, digital platforms have emerged as a crucial tool in providing counselling and mental health services to young people, addressing a pressing need in an increasingly connected, yet isolated, world.

The Exchange is an organisation that provides psychological wellbeing services for children, young people and families across Scotland and Wales. Clara Thomson manages one of their most remote counselling services located in the rural communities and islands of Argyll and Bute, Scotland, many of which are only accessed by ferry. In-person counselling is a year-round challenge that becomes even more difficult during the winter season. For this reason, the service is integrated with Digital EXchange Youth (D-EXY) (**www.d-exy.com**), which offers a hybrid model of support which is fundamental for children and young people isolated in remote locations. But digital platforms can offer more than this. Many provide a unique opportunity for early intervention. Online resources, self-assessment tools and chat-based counselling can guide young people towards understanding their emotions and seeking professional support before their issues escalate. The immediacy of these platforms – being able to connect with a counsellor or access resources at any time – can make a critical difference.

The shift towards digital mental health support seems to have been driven by several factors. First, the nature of digital platforms aligns with the habits and preferences of young people who are digital natives, comfortable with technology as a means of communication and self-expression. They are accustomed to interacting with peers, consuming content and seeking information online. Thus, providing mental health services through apps, websites and social media platforms makes them both more accessible and relatable.

Secondly, the stigma surrounding mental health issues, though slowly diminishing, remains a significant barrier for some young people. Traditional face-to-face counselling, while effective, can be intimidating for those who fear judgment or feel uncomfortable discussing sensitive issues in person. Digital platforms offer a more anonymous, accessible and non-threatening way to access help, lowering the barrier for those in need.

Thirdly, and most relevant to this time of year, access to support becomes a barrier for young people who have relied on school-based counselling provision when schools are closed for the holidays. Although counselling may be available in the community, not all young people will be able to access this, or have a reliable adult to take them.

However, while digital platforms offer many benefits, they also present challenges. Ensuring the quality and confidentiality of online counselling services is paramount. Young people need to know that they are receiving care from qualified professionals and that their personal information is secure. As we embrace digital mental health services, it is essential to establish clear standards and regulations regarding safeguarding.

Additionally, while digital platforms are a valuable tool, they should complement, not replace, traditional in-person counselling. Some issues require the depth and personal connection that face-to-face interactions provide. Hybrid models that combine online and offline support can offer the best of both worlds, catering to the varying needs and preferences of young people.

The rise of digital platforms for counselling and mental health support represents a significant advancement in how we support young people. By meeting them where they are – online – we can break down barriers to access, provide timely support and ultimately, foster a generation that is more open, aware and empowered to manage their mental health.

Emma Davies,
BACP CYPF Executive Committee Chair

All kinds of minds

Sarah Haywood explores the flavours of neurodiversity and the power of the language we use to describe them

I recently celebrated my two-year 'autistiversary' – the second anniversary of completing an autism assessment and being formally recognised as autistic. I described something of that process in a previous article,[1] and am delighted to be able to follow up here with some further reflections on the neurodiversity paradigm, specifically, how we talk about different kinds of minds. I'll focus on language because language is power.[2] It not only describes but shapes and influences the landscape we live in. It's also one of my passionate interests. Before I trained to be an art psychotherapist, I studied linguistics and worked for around a decade in academic language research. I'm no longer in that field day to day, but it continues to fascinate me. The way we talk about our services and those who use them can say a lot about our underlying values and beliefs as practitioners. Language also does much of the heavy lifting when it comes to creating the professional cultures in which we operate.

> Talk of difference and divergence can feel othering because it automatically marks out a so-called neurodivergent person as the special case, and implies that there is a neutral, 'normal' reference

I want to note at the outset that I'm curious to explore issues of language and power, and hopefully offer some helpful food for thought, but I'm in no way intending to try to police colleagues' language, or shame folks who haven't already considered the issues I'm talking about or those who see things differently to me. I also want to acknowledge the massive privilege I have in my own autistic life; being able to speak, write and understand a language, and actively enjoy using it, gives me access to mainstream culture and community in a way that many so-called 'non-verbal' autistic people simply do not have. I will come back to this point later.

The 'neurodiversity revolution', as I think of it, started in the 1990s and gained momentum through the noughties. Recently, it has received a lot of attention in mainstream media,[3] as well as academic and professional literature,[4,5] so there's a good chance that you're already familiar with at least some of the language that I'll be drawing on here. But in the spirit of 'no person left behind', I'm avoiding an assumption of any prior knowledge about neurodiversity, and I'll try to define or explain the jargon as I go. I'll lean heavily into ideas from autistic community specifically, because that happens to be the flavour of neurodiversity I know best through my own personal and professional experience.

What is neurodiversity?

Psychologist, author and educator Nick Walker has been an influential contributor to the emergence and development of the 'Neurodiversity Movement' since its inception. I find her succinct definition of neurodiversity very helpful. She says, 'Neurodiversity is the diversity of human minds, the infinite variation in neurocognitive functioning within our species.'[6] In other words, human minds differ in the ways they work, and that is neither inherently good nor bad, but simply a

feature of life's rich tapestry. Walker goes on to say, 'Neurodiversity is a biological fact. It's **not** a perspective, an approach, a belief, a political position, or a paradigm. That's the **neurodiversity paradigm**… not neurodiversity itself. Neurodiversity is **not** a political or social activist movement. That's the **Neurodiversity Movement**…not neurodiversity itself.'[6] (Emphases are in the original text).

As an autistic language geek, I very much appreciate Walker's careful attention to detail, and the linguistic effort she goes to in disentangling the social, political and constitutional aspects of neurodivergence. I also recognise that many folks whose 'bodyminds'[7] have traditionally been described using terms such as dyspraxia, dyslexia, Down's syndrome, attention deficit hyperactivity disorder (ADHD), dyscalculia, autistic spectrum disorder (ASD) and Tourette's syndrome, do not appreciate being labelled as 'divergent'. Talk of difference and divergence can feel othering because it automatically marks out a so-called neurodivergent person as the special case, and implies that there is a neutral, 'normal' reference point from which some of us deviate.

For these reasons, some folks refer to themselves as 'neurodiverse' or 'neurodistinct' rather than 'neurodivergent', while others eschew those kinds of descriptions altogether, choosing simply to say that they are a member of a 'neurominority group'. 'Neurominority' reflects the relatively small population of neurodivergent folks, compared with the neuromajority group often known as 'neurotypicals'. Current estimates put dyslexia as one of the more commonly occurring flavours of neurodivergence, with around 10% of the UK population thought to be dyslexic.[8] ADHD is less prevalent, with around 5% of the population being identified as having attention differences.[8] Autism is thought to occur even less frequently, with only 1–2% of the population currently recognised as autistic[8] (although this last figure at least is almost certainly an underestimate).[5]

While the numbers may be relatively small, for all the reasons outlined above, it's always good to ask members of neurominority groups how we would like to be known, rather than imposing your own language preferences on us. This becomes particularly important when a person's intersecting identities mean that they are especially likely to experience discrimination or exclusion (for example, consider the situation of a dysgraphic genderqueer person of colour with Tourette's syndrome and limitations on their mobility). Asking how a person wants to be known also gives an opportunity to hear whether they prefer to be described using person-first language (i.e. person with dyslexia) or identity-first language (i.e. dyslexic person). These alternative options are not readily available for all flavours of neurodivergence (e.g., ADHD), but where choice exists, it can be helpful and supportive to explicitly check it out. Worth noting is that a number of research studies suggest a majority of the English-speaking autistic community prefers identity-first language (autistic person).[9] This might come as a surprise for those of us who were trained to 'see the person before their autism', and talk about this particular flavour of neurodivergence as though it were an external appendage or accessory that a person 'has', e.g., 'person with autism', or the rather troubling (to me) formulation: 'person living with autism' – yuck!

(De-)pathologising neurodiversity

Emergence of the neurodiversity paradigm may well have played a part in the autistic community's current preference for identity-first language. Not so long ago, understanding autism as a disorder, using the language of pathology, was the only available option. Traditional approaches have historically taught us that neurodivergence is something that needs fixing or getting rid of. We're used to hearing about the 'symptoms' of neurodivergence, and the processes of 'assessment' that neurodivergent persons undergo to receive a 'diagnosis' of their (usually pathologised) 'condition', 'deficiency' or 'disorder'. Note that each of the terms in quote marks come from the medical model, and are usually used in the context of illness and disease – situations that we would rather not have to contend with, things we take medicine or have surgery to get rid of, or at the very least try to minimise and control.

The challenges that neurodivergent persons face in a world that is often not well tailored to our needs are certainly not ignored within the neurodiversity paradigm. However, we now have language that allows us to reframe neurodiversity, not as disorder but as part of a

person's constitution and identity, and to recognise the unique strengths and capacities that neurodivergent persons bring to our wonderfully colourful human world. Why is this important? Well, emerging research increasingly recognises that holding a positive neurodivergent identity is associated with wellbeing and self-esteem.[10] How easy or possible is it to develop a positive neurodivergent identity when the language used to describe us routinely frames our bodyminds as problems to be solved or disorders needing treatment?

> **What we say about neurodiversity matters, both within our therapeutic spaces and outside them in the wider community**

……

For these reasons, I'm working to de-pathologise my own language around autism and neurodiversity, and to share these ideas with the people I meet as a trainer and arts therapies educator. You may have noticed in this article that I try to avoid using the language of 'diagnosis' wherever possible, using 'discovery', 'identity' or 'recognition' as alternatives (e.g., 'I discovered I was autistic two years ago' and 'I was formally recognised/identified as autistic two years ago'). The language of support needs is now much preferred to the framing of neurodiversities in terms of 'functioning' or 'severity'. For example, instead of saying I have 'mild' autism or am 'high functioning' (as many of us will have been socialised to do), I describe myself as – and am extremely fortunate to be – a person who has 'low support needs' in many areas of my life. (It's probably worth noting that that there are also places where my support needs are higher, they're just generally less visible in professional life than at home.) I also talk about autistic experience and culture rather than the 'symptoms' of autism.[11] Reframing autistic experience as a distinct culture has been a game-changer for me; it allows me to simultaneously acknowledge the challenges and difficulties that being autistic brings, while also celebrating the wonderful things that make me who I am and that I wouldn't be without.

I also encourage folks to consider whether autistic people who don't use speech as their primary form of communication are truly 'non-verbal', which might imply the absence of access to any kind of language, or could be more accurately described as 'non-speaking'. I would wager that all of these folks have rich internal experiences, and it's clear that some have exceptional written communication skills[12] but just don't use 'mouthwords' to share their internal world with others. 'Mouthwords' are, as the term suggests, spoken words that come out of our mouths, rather than words that appear in written form. This is one of many excellent new phrases that I've acquired since being welcomed into neurodivergent community. In a world that prioritises, prizes and valorises talking and oration, being a non-speaking person brings a bunch of significant challenges in everyday living, not to mention negative assumptions about competence and capacity, and a marginalised, stigmatised social status.

How inclusive is inclusivity?

One final thought is around the language of 'inclusion' when we talk about neurodiversity – or any other dimension on which humans differ. As an openly autistic practitioner, I now find myself in a number of roles and spaces where I am invited to speak to issues of equality, diversity and inclusion (EDI) in my professional life, and I really welcome and enjoy these opportunities. Recently, I was struck by Myira's Khan's writing about the problems of inclusion and inclusivity when we think about ourselves as helping professionals.[13] Khan helpfully points out that the language of 'inclusion', while well-intentioned, is intrinsically othering because it implies that there is an 'inside' and an 'outside', and reinforces a situation where privileged individuals (which often includes those of us in the helping professions) have the power and means to invite outsiders in – or keep them out. In Khan's own words, 'Being inclusive means to include those who are oppressed but still maintain your power by positioning yourselves as normative, neutral, central and invisible.

Inclusive implies that there must be a level of exclusion taking place. Being exclusionary means using your power to put up barriers and having the power, dominance and authority to choose who you include and exclude.'[13] (p29). Perhaps in time, we might move away from a focus on EDI towards something like EDB – equity, diversity and belonging – where belonging is something that we all have the capacity to seek, promote and enjoy on our own terms. We may have to wait for someone else to include us, but we can decide for ourselves where and when we experience a sense of belonging.

In this article, I've made a case for more conscious, intentional and anti-oppressive language when we talk about neurodiversity.[2] I hope to have persuaded you that our language choices have impact and help to shape how neurodivergent persons think and feel about themselves.[10] We have tremendous power, as helping professionals, to influence not only how our neurodivergent service users and colleagues experience themselves, but also to shape public narratives about neurodiversity.[11] Language is power. What we say about neurodiversity matters, both within our therapeutic spaces and outside them in the wider community.

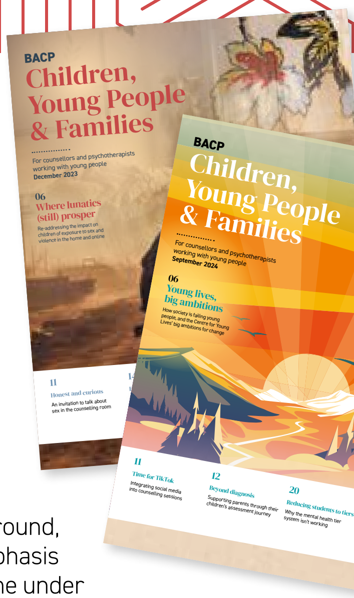
I write here as a white, cisgender, able-bodied person fortunate to have a huge amount of privilege in my life, including the luxury of time and space to contemplate and write about language in the abstract. I've said it already, but it bears repeating: it is not my wish to create feelings of shame or guilt in relation to the languaging of neurodiversity, and it is certainly not my intention to police or criticise anyone else's language use. Unless you recently completed a neurodiversity-affirming professional training, you will almost certainly have been socialised to do and say pretty much *all* of the things I've cautioned against in this article, such as using the term autistic spectrum 'disorder', talking about the 'symptoms' of ADHD and the 'diagnosis' of neurodivergence, and so on. Like me, you will probably have heard some things coming out of your mouth, when talking to or about neurodivergent service users and their communities, that in retrospect might feel problematic.

I urge you to keep the faith. As helping professionals, we're generally all doing the best we can, and to paraphrase the poet and civil rights activist Maya Angelou, you can only 'do the best you can until you know better. Then when you know better, do better.'[14] My hope in offering these thoughts is that when we know better about neurodiversity, each of us can do better by contributing to a world where all kinds of minds and flavours of neurodiversity are welcomed and supported to flourish. ■

Sarah Haywood is a supervisor and trainer in private practice, and a lecturer on the MSc Art Psychotherapy programme at Queen Margaret University, East Lothian. She is the lead associate editor for equality, diversity and inclusion (EDI) at the *International Journal of Art Therapy: Inscape*, and also leads the British Association of Art Therapists' diploma programme in art therapy supervision. As a practitioner, she currently works with children and young people, particularly with young people affected by drug use in their families.

References

1 Haywood S. Different, not deficient. BACP Children, Young People and Families 2023; September: 11–13.
2 Kapitan A, Kapitan L. Language is power: anti-oppressive, conscious language in art therapy practice. International Journal of Art Therapy 2023; 28(1–2): 65–73.
3 BBC. Inside our autistic minds [Television.] Joe Myerscough (dir.) BBC2 2023; 14 February. https://tinyurl.com/37s2ryby
4 Leza J. An introduction to neurodiversity and autistic culture for (music) therapists. Texas: La Migdalia Press; 2023.
5 Anna Freud. Supporting autistic children and young people. [Online.] https://tinyurl.com/bd583k5j (accessed 09 September 2024).
6 Neuroqueer. Neurodiversity: some basic terms and definitions. [Online.] https://tinyurl.com/bdfufv2e (accessed 09 September 2024).
7 Dychtwald K. Bodymind. New York: Pantheon; 1986.
8 Genuis Within. What is neurodiversity? [Online.] https://tinyurl.com/4h67uvvw (accessed 09 September 2024).
9 Keating CT, Hickman L, Leung J, Monk R, Montgomery A, Heath H, Sowden S. Autism-related language preferences of English-speaking individuals across the globe: a mixed methods investigation. Autism Research 2023; 16: 406–428. https://tinyurl.com/ehnt6asc
10 Corden K, Brewer R, Cage E. Personal identity after an autism diagnosis: relationships with self-esteem, mental wellbeing, and diagnostic timing. [Online.] Frontiers in Psychology 2021; 12. https://tinyurl.com/2eu75f9w (accessed 09 September 2024).
11 Davies H. Autism is a way of being: an 'insider perspective' on neurodiversity, music therapy and social justice. British Journal of Music Therapy 2022; 36(1): 16–26.
12 Higashida N. The reason I jump: one boy's voice from the silence of autism. London: Sceptre; 2013.
13 Khan M. Working within diversity: a reflective guide to anti-oppressive practice in counselling and therapy. London: Jessica Kingsley Publishers; 2023.
14 Quote Investigator. You did what you knew how to do, and when you knew better, you did better. https://tinyurl.com/k2st67u4 (accessed 20 September 2024).



Readers' survey

Editor **Jeanine Connor** shares the results of the latest readers' survey

There was a fantastic response to the readers' survey, sent direct to divisional member's inboxes sometime in the spring, and I received the anonymised results just before the September issue went into production. I've pored over your comments and am pleased to share key findings with you here.

What you liked about the journal

The word that came up most frequently was 'relevant', which absolutely delights me as this is something I strive to achieve and is not always easy with a quarterly publication. Elaborations described the journal as informative, interesting and inspiring, with content that is pertinent to your practice, no matter what setting you work in. Lots of readers liked the wide variety of topics we include, and valued the different styles and perspectives of our contributors. This delights me too, because I commission carefully to bring together a range of themes and diverse voices in a very limited amount of space.

Feedback about the contributors

Some respondents queried the clinical experience of our contributors. I strive to include articles from counsellors and psychotherapists with a wide range of experience, including trainees as well as those with a few or many years in practice. I want the journal to reflect our readership, whether you're in training or highly experienced, and I welcome proposals across the board.

Sometimes I commission articles from allied professionals working with children and young people in related fields, such as research, health or social care, or education. This reflects the way that many of us work in practice, joining with other agencies around the young person and their family to think together and learn from different disciplines.

Equality, diversity and inclusion (EDI)

The vast majority of you shared that our journal feels inclusive of diverse genders, sexualities, ethnicities, abilities and cultural backgrounds. I strive to reflect EDI both in the themes of the articles and the people who write them. It is worth noting that we only include contributors' names and short biographical details, which leads to assumptions, sometimes inaccurate ones, about gender, sexuality and ethnicity. Despite a minority of comments that we include too much about gender, sexuality and race, I will continue to aspire to a journal that feels diverse and inclusive.

Suggestions for ways we can improve

As with all questions in the survey, responses here reflected the subjective opinions of readers. Some asked for more short articles, while others want more long ones. Some want more illustrations, while others want more words on the page. Some asked for more articles about creative ways of working, while others want more academic articles. As I said in my September editorial, 'you can't please all of the people all of the time', but that won't stop me trying!

If you're anything like me in your reading habits, you will scan the contents page when your issue lands and turn straight to the articles that resonate most. But I invite you to scan the pages that don't immediately resonate too, so that you broaden your knowledge of working with children, young people and families. I know from speaking to members that there are some who lock themselves away with a cup of tea and their paper copy and read everything cover to cover – hopefully they discover something stimulating every time. And now you can read the journal on your electronic devices with the newly launched FlipBook, making reading online a livelier experience.

Topics you want to see more of

I noticed a slight shift in the topics you'd like to see more of this time around, with an explicit emphasis on themes that come under the umbrella of young people's online worlds. This includes online relationships and bullying, e-safety, addictive behaviour in relation to smartphones and tablets, and young people's use of social media. I think this reflects the themes coming up in our work (which I recognise from my own practice), as well as recent headlines in the news and social media about the potentially damaging effects of online harms. I invite proposals from members with a special interest or experience in all things digital; but let's celebrate the positives as well as acknowledging the negatives.

The other topics that featured highly in what you'd like to see more of, like last year, are gender, sexuality and neurodiversity. I've already commissioned articles on each of these topics for issues coming soon. Again, I invite you to send me your proposals if you have something to add to the conversations around these significant themes.

Future feedback

I always appreciate feedback from readers, whether that's in response to the annual survey, via email direct to my inbox, or in person at BACP events. It's fabulous to hear you praising something we've done well, but equally, I value your suggestions for ways we could improve. This is *our* journal, specifically commissioned for those of us working with children, young people and families, in a range of settings with diverse personal and professional experiences. I want to reflect those diversities, and my inbox is always open for comments and proposals: **cypf.editorial@bacp.co.uk**

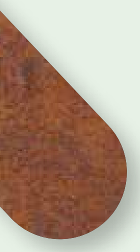
Jeanine Connor, Editor

Are you culturally competent?

Naomi Angelica Vibrati invites us to challenge our assumptions, examine microaggressions, and consider cultural competence and humility

How did your core training to become a counsellor or psychotherapist address cultural competence? Do you think it is an innate part of our skillset, or something we intentionally develop? I am what's known as a 'third culture kid', meaning I grew up in a culture different to the one my parents grew up in, and was influenced both by my parents' culture and the culture in which I was raised. I spent most of my childhood in a context where I didn't see other children who looked like me, aside from members of my family. I had a different skin colour, hair type and cultural background to my peers, which affected how they treated me. Sometimes, when peers saw past the colour of my skin, I could blend in, but this also meant they 'invisibled' aspects of my identity, like my mixed heritage, race, cultural context, beliefs and worldview. Being treated differently meant that no matter how hard I tried, I was never going to be like 'them', and the visible aspects of my appearance were constant reminders of my difference.

Today, as I reflect on this childhood experience, it brings up mixed feelings. I have learnt to unpack the layers of experience, from holding privilege in certain contexts, to understanding internalised racism, to the difference between fitting in and belonging. In my teen and adult years, these layers became more or less apparent depending on the country I lived in and the beliefs of the dominant culture. It was challenging because I knew that depending on where I lived, I would either experience oppression or hold privilege.



Cultural competence

I share a glimpse of my story because when we talk about cultural competence, introspection plays an important role in recognising and understanding our own worldview, beliefs and experiences, and how these can influence our therapeutic practice. The NHS defines cultural competence as, 'A set of aligned and transparent skills, attitudes and principles that acknowledge, respect and work together as a system towards optimal interactions between individuals and the various cultural and ethnic groups within a community.'[1] The National Institute for Health and Care Excellence (NICE) defines it as, 'The ability to understand and respond to a person's particular religious, cultural or language needs and experiences.'[2] Fundamentally, cultural competence is about the knowledge and skills we have about our own cultural values and awareness, and the sensitivity and competence we have towards others. The challenge is understanding what this looks like in theory, and applying it in practice, which led me to wonder whether we need to be trained to be culturally competent, or whether it develops from the counselling skills we already have.

> **My training focused on theory and practice, but it was Eurocentric, without a deeper understanding of what my practice would look like for clients of various cultural backgrounds**

We know that culture is an integral part of a child's sense of self and relationships. Culture impacts child development in influencing the way we learn, think and behave. It also has an impact on areas like language and communication, social and emotional development, and value systems of individualism and collectivism.[3] If we refer to the iceberg metaphor, there are aspects of a child's identity that are visible and aspects that aren't. Assumptions are made which will be used to either oppress or place a person in a position of privilege. Dr Turner's book, *Intersections of Privilege and Otherness in Counselling and Psychotherapy*,[4] is one of the few which has helped me to understand the intersectionality of difference, be it cultural, gendered or different ability. However, culture isn't stagnant which means our competence in this area should be dynamic, and relying on our core training to work in a multicultural environment isn't enough. Rather than focusing on trying to accumulate a knowledge of all cultures, which is a more content-based approach, I try to focus instead on a process-oriented approach of cultural humility.[5] On an intrapersonal level, this means being aware of my own biases and any potential impact my culture could have on my thought processes, while on an interpersonal level, it means recognising my own limits in knowledge and expertise when it comes to an individual client's cultural experience which may be unfamiliar. As I develop my cultural competence and humility, I often reflect on assumptions in and out of the therapy room.

Microaggressions and assumptions

We all make assumptions; it is a part of human cognition. In our therapeutic practice, we learn to explore these, understand and challenge them. Assumptions make their way into all aspects of our lives, even when we are unaware of them. Although I have worked with children and young people who may look like me, this doesn't equate to knowing their lived experience, frame of reference, cultural background or worldview. This is an important reminder when it comes to assumptions. Perceiving to have the same cultural background can raise a sense of having a shared understanding, or overestimating comfort and rapport. Going back to visible and less visible aspects about myself and my background; people have made assumptions about me, many of which have presented as microaggressions.

Microaggressions have been defined as the inadvertent and subtle messages that demean, insult and invalidate a person, which can be communicated verbally or non-verbally, intentionally or unintentionally.[6] Research tells us that microaggressions can have profound negative effects on our wellbeing and mental health, especially because they are usually cumulative.[7] Once I became aware of them, I began to unpick the microaggressions I have received from childhood to date. They were often the same ones repeated by various individuals, increasing my frustration when the next person made the same comment, unaware of the cumulative impact.

Microaggressions often stem from assumptions based on how others perceive my cultural characteristics. Some of the most common ones I've heard are, 'Where are you *really* from?', 'I can't believe how well you speak Italian', or comments about being 'white on the inside' because of my sense of fashion or mannerisms. Non-verbal microaggressions can relate to posture, for example, turning away from someone, or invisibilisation, which is a form of othering, as if to imply 'I don't see you' or 'I don't recognise you'. This can also take the form of confusing me for another person who is black because we are seen as interchangeable – and therefore not seen at all. Some of the microaggressions that can find their way into our therapy room relate to assumptions we make based on appearance. For example, assuming an Asian British person is foreign born and 'alien' because their appearance doesn't fit the stereotype of what a British person 'should' look like. Another example is 'ascription of intelligence' – high or low –

based on a person's race. For example, assuming someone from India will excel at maths and science. 'Colour blindness' typically stems from an effort to create unity and involves trying to treat everyone equally regardless of their race or ethnicity. But this can be seen as a microaggression too because it disregards diversity and creates the opposite effect to unity – oppression. Another microaggression is pathologising cultural values or communication styles which vary from the values and styles of the dominant culture. For example, suggesting someone is too animated in their mannerisms.[8] The riots this summer, across 27 UK towns and cities, were fuelled by racism and Islamophobia. They demonstrate the impact of racial stereotypes and the profound roots in historical imperial biases. They also serve as a significant reminder of the importance of understanding and addressing our own assumptions.

> **Microaggressions often stem from assumptions based on how others perceive my cultural characteristics**

Pathways of development

A key aspect of my core counselling training centred around unconditional positive regard, valuing the client without judgment or criticism. This initially led me to believe that I could offer counselling to everyone, but I soon realised that when it came to cultural competence, I could not confidently and comfortably understand how all the different protected characteristics like race, ethnicity, disability, religion, gender and sexuality can be experienced, or consider all experiences of intersectionality, privilege and oppression. My training focused on theory and practice, but it was Eurocentric, without a deeper understanding of what my practice would look like for clients of various cultural backgrounds.

My own worldview is my frame of reference, and although I reflect on biases and assumptions in clinical supervision, I cannot recognise all the complexities of power, privilege and oppression that exist within communities, which can feel daunting. We cannot be experts in every aspect of human experience, and we don't need to be, but we do need to recognise our own limitations and build on our competence through continued professional development in areas like equality, diversity, inclusion and belonging. I have found it helpful to attend workshops, listen to podcasts and read books, but also to remain curious around cultural identity with clients and colleagues.

I started from a place of introspection, asking myself questions about the power I may bring to the counselling room from the groups I belong to, and the beliefs I hold about identity, gender, sexuality, religion and families. Within my practice in an international school setting, multiculturalism is presented to me every day, and I am constantly reminded how my frame of reference can be so different from that of the children and young people I meet.

Building my cultural competence means I have made mistakes, but I am intentionally trying to understand my cultural biases and how they affect the therapeutic relationship, and I am educating myself about my own cultural background and that of the students I work with. It is a reflective journey and an evolving skillset that requires effort and commitment to provide respectful care to a diverse client population. ■

Naomi Angelica Vibrati MBACP is a lead school counsellor in an international school. She has a particular interest in diversity, equity, inclusion and belonging. Naomi is also a 'third culture kid'.

References

1 NHS. What is cultural competency? [Online.] https://tinyurl.com/4sfbj86h (accessed August 2024).

2 National Institute for Health and Care Excellence (NICE). Cultural competence. [Online.] https://tinyurl.com/3ks5hzf8 (accessed August 2024).

3 Greenfield P, Rothstein-Fisch C, Trumbull E, Quiroz B. Bridging cultures in early childhood education. [Online.] https://tinyurl.com/ycyffjvr (accessed September 2024).

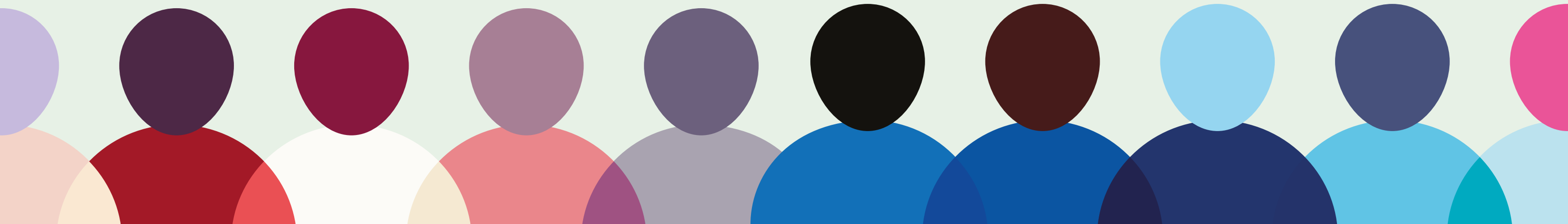
4 Turner D. Intersections of privilege and otherness in counselling and psychotherapy. place: Routledge; 2021.

5 Lekas HM, Pahl K, Fuller LC. Rethinking cultural competence: shifting to cultural humility. Health Services Insights [Online.] https://tinyurl.com/2s4jd2hx (accessed September 2024).

6 Miles JR, Anders C, Kivlighan DM, Belcher Platt AA. Cultural ruptures: addressing microaggressions in group therapy. Group Dynamics: Theory, Research, and Practice 2021; March: 25(1): 74–88.

7 Nadal KL, Griffin KE, Wong Y, Hamit S, Rasmus M. The impact of racial microaggressions on mental health: counselling implications for clients of colour. Journal of Counselling & Development 2014 January: 92(1): 57–66.

8 Sue DW, Capodilupo CM, Torino GC, Bucceri JM, Holder AMB, Nadal KL, Esquilin M. Racial microaggressions in everyday life: implications for clinical practice. American Psychologist 2007; 62(4): 271–86.



Deeping it

David Cook explores existential themes like death, meaninglessness, midlife and 'adolescent doldrums'

Curtis, 15, is slumped in a chair in my school counselling room, dark rings under his eyes. He's got a lot on his mind.

'What if Naomi leaves me? What if my dad walks out again? What if I mess my mocks up?' He lapses into silence, before continuing, 'But then, sometimes I think I'm just a speck on a tiny rock drifting through the cosmos. My life is just so… unimportant.'

'Wow, that's quite a shift in perspective,' I comment.

'I know right, I'm deeping it!'

'Deeping it' is one of my favourite phrases that I've heard from young clients. I understand it as going deep in our thinking, searching for meaning beyond the surface. One of the joys of working with adolescents is that they are often stirred by 'deep', existential themes. Existentialism is a branch of philosophy that incorporates a broad range of thinkers and issues, but at its core is the question of what it means to exist as a person. Existential thinkers believe that we each experience a unique subjective reality, yet struggle with the same basic concerns relating to our existence.[1] These existential givens have been formulated in various ways, but perhaps most succinctly by existential therapist Irvin Yalom as death, freedom, isolation and meaninglessness.[2]

The changes we experience in adolescence mean that this period is often a first awakening to these concerns, and a time when they take on a raw and urgent importance.[3] I recently felt inspired by the way case material can bring theory to life by psychotherapist Jeanine Connor's latest book,[4] and have created two fictional clients, to give a flavour of how existential givens can present in adolescent work.

Death and meaninglessness

Della, 16, kneads the ball of clay, pushing her thumbs heavily along the surface and gouging channels around its circumference. The clay gathers under her false nails. All the while, she chats away, telling me in great detail about *My Little Pony*, the animated TV show she used to love. I watch as the grooves in the clay get more pronounced, and listen as I'm told more about the world of Pinkie Pie and Applejack. I'm grateful to see Della today, she often isn't in school, and this is the first day she's made it in this week. I'm struck by her enthusiasm for a show she originally watched as a child, and the contrast between this and her nails, which seem designed to signal maturity. I often come across a sense of loss and grief in teenage clients for their early years. The psychotherapist Richard Frankel writes that adolescents are experientially undergoing a dying process as they move away from childhood, and so are particularly attuned to the mortality of our existence.[5]

> **…an awareness of the way existential issues can begin to bite as we transition to adulthood adds an important dimension to our understanding**

……

As Della approaches adulthood, she is gaining a concrete awareness that things change, end, and ultimately life is finite. Perhaps it is understandable that, faced with this, she is spending a lot of time in bed. Counsellor Nick Luxmoore speculated that in such behaviour, adolescents 'avoid death by effectively avoiding life'.[6] But it also strikes me that as childhood recedes, we lose the taken-for-granted meaning of life and of our own identity. Previously these things were given and received without question, but now they are in doubt, which can be stultifying. Child psychoanalyst Donald Winnicott describes the 'adolescent doldrums', as a phase characterised by feelings of futility and stasis, which is a necessary part of becoming our own person and finding our own way forward.[5,7]

'School is so dead', says Della. 'What's the point? I'm going to fail my exams and I don't know what to do with the rest of my life.' I wonder if she is avoiding the 'death' of exam failure by not trying. And terrible though it is, maybe her fear of exam failure is easier to handle than her fear of one day not existing. We often cope with existential angst by focusing our anxiety on something more tangible.[8]

But Della also seems to be rejecting what school has presented as the 'meaningful' way forward. In contrast to many psychological theories, which look to the past to explain the present, existential thinkers often emphasise how our orientation towards future possibilities affects how we make meaning in the here and now.[1] Della sees no meaning in the future offered by exams. Her current outlook can be regarded as part of her struggle to envisage an alternative path and make sense of her growing awareness of her own mortality.

Della puts the clay down. She has pushed her thumbs all the way through, making a tunnel to the other side. I ask her if she has a name for it. She considers for a moment, then says, 'It's called "the void"'.

Freedom and isolation

Kayleigh, 13, is choosing pebbles representing people in her life and placing them on a piece of black paper. 'The one like a mirror is my mum', she says. 'Sometimes, it's basically like we're the same person'. She selects a small, brightly coloured stone to symbolise herself and lays it at a distance from the mirrored pebble. 'We fell out again last night. She said I never spend any time with her, because I'm always in my room or out with friends.'

While Yalom stresses our essential isolation from every other being,[2] existential thinkers such as Martin Buber emphasise that we are intersubjective beings: we *are* our relationships.[9] Kayleigh's current experience encompasses both these aspects of being. Until recently, she identified strongly with her mother, but now deepening relationships with friends are becoming more important. In adolescence, we separate from parents or carers and find our own identity. Experiencing isolation in her room feels to be an important part of the process of Kayleigh working out who she is when she is not part of a closely linked dyad with her mother. This 'breaking free' can be unsettling. Yalom describes the realisation that no one else has responsibility for our lives as 'the loneliness of being one's own parent'.[2]

'I had a panic attack on Tuesday. I couldn't breathe,' says Kayleigh.

'That sounds really scary. What happened?' I ask.

'Mum was dropping me off at my drama group. I always get nervous, but if mum walks me in I'm usually alright. This week I just couldn't. Mum tried to calm me down, but I thought I was going to faint.'

Previously, Kayleigh's mother could contain her anxiety; if she told her it was alright, then it was alright. As their relationship shifts, Kayleigh's belief in her mother's omniscience is waning.

The existentialist philosopher Martin Heidegger used the term '*dasein*', or 'being-there', to highlight that we are inseparable from, and limited by, our context.[10] We are thrown into a particular set of circumstances over which we have no control. Yet, we also create our context: we have the freedom to choose and change the meanings we attach to things, and the way we relate to the limitations of our existence.[11] When Kayleigh was a child, her mother shaped her reality and her sense of self. Now, at some level, she is gaining a sense of responsibility for her own existence, and this is disturbing. Yalom writes of the experience of our own ultimate responsibility as 'a dizzying sensation', which evokes a feeling of 'groundlessness', as if the ground beneath us opens up, and we have nothing solid and certain to stand on.[2]

'Mum always tries to tell me what to do, she doesn't realise I'm too old for that now', says Kayleigh biting her lip. I look down at her pebbles. On the black paper, it looks to me like the bright stone is spinning off into space, and I wonder if Kayleigh is feeling similarly untethered as she becomes more aware of her freedom to shape her own life.

Facing the existential

There are many ways of trying to make sense of what is going on for Della, Kayleigh and all the other adolescent clients we meet. I think an awareness of the way existential issues can begin to bite as we transition to adulthood adds an important dimension to our understanding. As adults, we are no less affected by existential concerns, but we often distance ourselves from them. In my own midlife, I struggle with choices and doubts, strive for meaning and connection; all framed by the knowledge that time speeds on towards my death. This can come to the fore when I experience a shocking event but day to day, I avoid the intensity of my existential reality.

> Existential givens are the ultimate leveller, and we are equally as likely as our clients to respond to them with feelings of confusion, angst and despair

Existential issues are often not talked about by adults in everyday life, and consequently adolescents can appreciate it when we are willing to engage with them on this level. Existential givens are the ultimate leveller, and we are equally as likely as our clients to respond to them with feelings of confusion, angst and despair. Just like our clients, we have no firm answers when contemplating existence. But we do not need answers to be of help. What we can do is develop our capacity for 'existential empathy', 'to attune to and resonate with the existential layer of the client's experience, and symbolise and communicate this back to the client'.[1] But this is not an easy task. Research suggests that encountering adolescent clients' existential concerns can awaken those of the therapist and that this can feel overwhelming.[12] It has also been found that increasing our awareness of our own existential reality enhances our ability to engage in such work with clients.[13]

I take from this that the more we can be open to our own existential layer, the more we will be able to empathise with clients' experience at this depth. My perspective on death, meaninglessness, freedom and isolation will certainly be different to that of adolescents, but the more I can face these givens, the more I can 'deep it' with them as they make sense of their own existence. ■

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References

1 Vanhooren S, Cooper M. Existentially informed person-centred therapy. In: Cooper M. (ed). The tribes of the person-centred nation. Monmouth: PCCS Books; 2024 (pp183–200).

2 Yalom I. Existential psychotherapy. New York: Basic Books; 1980.

3 Fitzgerald B. An existential view of adolescent development. Adolescence 2005; 40(160): 793–799.

4 Connor J. You're not my f*cking mother and other things Gen Z say in therapy. Monmouth: PCCS Books; 2024.

5 Frankel R. The adolescent psyche, Jungian and Winnicottian perspectives. Hove: Routledge; 1998.

6 Luxmoore N. Young people, death and the unfairness of everything. London: Jessica Kingsley; 2012.

7 Winnicott DW. Struggling through the doldrums. In: Winnicott C, Shepherd S, Davis M, (eds). Deprivation and delinquency. London: Routledge; 1990 (pp145– 155).

8 Hollis J. Swamplands of the soul, new life in dismal places. Toronto: Inner City Books; 1996.

9 Worsley R. The ground of our relating: Martin Buber's I and Thou. In: Haugh S, Paul S, (eds). The therapeutic relationship, perspectives and themes. Monmouth: PCCS Books; 2008 (pp181–191).

10 van Deurzen E, Kenward R. Dictionary of existential psychotherapy and counselling. London: Sage; 2005.

11 Spinelli E. The interpreted world, an introduction to phenomenological psychology. London: Sage; 2005.

12 Lundvall M, Lindberg E, Hörberg U, Palmér L, Carlsson G. Healthcare professionals' lived experiences of conversations with young adults expressing existential concerns. Scandinavian Journal of Caring Sciences 2018; 33(1): 136– 143.

13 Frediani G, Krieckemans L, Seijnaeve A, Vanhooren S. Engaging with the client's existential concerns: the impact on therapists and counselors. Person-centered & Experiential Psychotherapies 2023; 22(3): 283–302.

Columnists

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

In training: Meeting the parents

Sue Kegerreis

Students who train as counsellors and therapists for children and young people are sometimes wary of meeting the child's parents. Their choice of specialism often has roots in their own difficult experiences growing up, meaning they identify strongly with the child, and at times with (conscious and unconscious) hostility towards parents. They may feel they connect well with children but are less confident about doing so with adults. They can fear that meeting parents will compromise their client's sense of them being 'their' person, which can even slip into a need to be seen as 'on their client's side'. Those who work in, and with, the transference can fear that any connection with the family will interfere with the work. (Historically, child psychotherapists would have someone else working with parents for this reason.)

However, a good connection with parents is vital. Handing your child over to a therapist is a huge step for parents, so the trainee needs to be available to help them think this through, and give them a good sense of who they are and how they can help. This will facilitate both initial and ongoing consent for the work to happen, and help mitigate loyalty conflicts for the child. No work can thrive if the parents are in opposition to it.

The trainee's understanding of their client will always be enhanced by having a fuller sense of the family dynamics around them, and meeting parents can provide useful clarity about the interplay of fantasy and reality in what emerges in the counselling room. The consultation can also be a rare moment for the parents' own anxieties and frustrations to be heard, with thought and compassion, as well as making possible some gentle psychoeducation, if needed. This therapeutic possibility can feed back helpfully into the child's home life.

The task for trainers is to help students hold meetings with parents with confidence, both in the offer they are making – which to a beginner can be a challenge – and in the immense value of being able to listen properly to the parents' contributions without losing access to the child's perspective. Often, trainees see it as a way of finding things out, and have to be helped to go into parent meetings with a more open mind and wider agenda. While it is useful to get information from the parents about the child, and sometimes we do gain important insights into their and their family's story, the greatest value is in creating an alliance around the child's emotional needs, and a shared understanding of how best to address them.

This is not therapy for parents, but it contributes significantly to effective therapy for their children.

Sue Kegerreis is course director of MA Psychodynamic Counselling and Psychotherapy at the University of Essex. She is both a child and adult psychotherapist who has practised in health, education and community settings, and privately.

In counselling: Kooshable reach

Samantha Johnson

Like many school counsellors, I have a stash of fun and curious objects which invite restless fingers to fiddle mindlessly. Some were inherited from previous counsellors; others are objects from my childhood. The most prized by far is my Koosh ball, which lives in what I call the 'fun drawer.' This drawer had been opened spontaneously by several students over the years, as they explored what was and wasn't allowed in our room, and what I might have hiding up my metaphorical sleeve. After I surrendered a fair amount of Blu Tack, I decided to put the office supplies (not allowed) one drawer down. Now, the top drawer, the fun drawer, contains cards, puzzles, pocket quiz games, monstrous figurines and other oddments. The Koosh ball is a colourful explosion of elastic protrusions, slightly larger than a tennis ball.

'What is that?' enquires Sophie, a softly-spoken Year 8 student who has been referred because her father passed away suddenly the previous month. I have opened the drawer and invited her to rummage after completing an intake assessment. I have introduced myself and spoken about confidentiality and its limits. She has answered some questions about her family, what stresses her out and what she enjoys. The whole process might only take 10 minutes, but this is delicate work, requiring a lightness of touch amid the heaviness of what has brought her to the counselling room.

'That,' I reply, 'is a Koosh ball. I have had it since I was your age. Have you seen one before?' Sophie says she hasn't.

> I wonder silently about what she might want to hold on to and what she might want to cast away; how the yo-yo rhythm might comfort her while she decides
>
> *– Samantha Johnson*

I explain they were big in the US in the 1980s, and I have many fond memories of this particular ball. I find a loop of elastic and stick my finger through, showing her how you can make the ball bounce like a yo-yo.

As I handle it, I am reminded of throwing it across bunk beds at summer camp. When it fell to the ground, my best friend and I would dangle from the top bunk and pick it up with our toes, calling out, 'Kooshable reach!' We proclaimed our invented catchphrase with unabashed silliness and joy. We held on to our child-like playfulness, even as our worlds were stretching and changing with the dawning of adolescence.

I don't tell all this to Sophie, but I suspect she can see the touch of childlike glee that animates me as I pass the Koosh ball to her. It lands softly in her hands, and she smiles. I wonder silently about what she might want to hold on to and what she might want to cast away; how the yo-yo rhythm might comfort her while she decides. I note that our time is almost up and ask if she would like to return next week. She does. I've reached her.

Samantha Johnson MBACP (Accred) is lead counsellor at a state secondary school in Oxfordshire, where she also runs a small private practice. **samjohnsonoxford.net**

In supervision: Keeping time

Elizabeth Holt

Time is a valuable asset. In therapy, time and space from another person are often all many people seek. Yet, difficulties with time management in sessions is common. In the early days of my counselling career, I brought this to my then supervisor, as I grappled with the skills needed to bring a session to a close, and worried about 'cutting the client off' when they were in full flow. Although there are occasions where an ending may feel sudden, the skill of a therapist lies in their ability to support a client to bring a session to an end long before the time is up, by offering scaffolding and transparency of the time that we have available.

While some therapists may feel uncomfortable with the idea of asserting any control in a session, it is the therapist's responsibility to keep the time: contracting clearly and discussing this transparently can help, especially if a counsellor feels uncomfortable with the client not feeling empowered during the closing of the session. A well-structured session includes a beginning, middle and end that allow the client to feel contained and supported in the therapeutic space. The therapist must therefore hold the skill to gently guide the conversation and support the natural rhythm of the session within the agreed timeframe.

When counsellors and psychotherapists bring difficulties with time management to supervision, it is often a reflection of their deeper struggle with setting and maintaining boundaries. It can be useful to explore these feelings in supervision to address the discomfort. A key strategy to support time boundaries is to introduce subtle time markers. This might include briefly mentioning the middle of a session, or noting when there is 20 minutes left. Note at the beginning of a session that there will be a gentle reminder 10 minutes before the end to keep time, and allow therapist and client to create a collaborative ending. If the end of a session is fast-approaching, the client could be invited to work further with whatever is being discussed in the next session, and create a short plan of how to approach it in the meantime, such as through a between-session task or self-care activity. This is something I model with supervisees so they can see how the strategies work in practice.

The importance of time management goes beyond the clock. It enhances the experience of being supported in the safe container of therapy (or supervision), where the counsellor (or supervisor) has the skills to navigate endings. Thinking of the therapist (or supervisor) as 'the keeper of the time' enhances the therapeutic relationship, rather than obstructing it, so that effective, respectful spaces with clearly communicated and upheld boundaries are maintained.

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With *networks* in mind

Imogen Nevard advocates for network-conscious working with children affected by parental mental illness

Talking therapies often have a focus on individuals. However, broader social networks, including active, significant social ties, are often tantamount to the wellbeing and quality of life of an individual client. The typically positive influence of these networks has been well documented in adults with mental health difficulties.[1] Less studied, is the role of social networks for their children. This is particularly relevant considering that the majority of adults with mental health problems are parents.[2] Estimates suggest that between 14 and 20% of children have a parent with a mental illness, and these children in turn face a higher risk (between 41 and 70%) of developing mental health problems themselves.[3,4] This is in tandem with other negative outcomes including academic difficulties, psychosocial and behavioural problems, and poor health-related quality of life.[3,4]

Social care prioritises keeping families together where possible, and interventions increasingly favour whole-family approaches. It is essential that professionals understand how best to support families affected by parental mental ill health, in the context of existing networks, to ensure the wellbeing of parent and child, while taking safeguarding priorities into account. It is necessary to contextualise the risks within broader structures and social environments, including poverty, social stigma, discrimination, lack of access to resources and limited provision of healthcare.

However, it is also important for us to situate families and children in their own social context. They are part of a community that includes friends, immediate and extended family, acquaintances and professionals, all of whom play some role in influencing wellbeing. Professionals forming social networks include teachers, social workers and mental health professionals, who present significant resources to children and families, but can be overlooked by clinicians working one to one with either parents or children. The research presented here demonstrates the importance of 'network-conscious' working, which is working with parents and children, with an awareness of the relevance of peripheral personal connections available to the family. By tapping into these networks, professionals can offer more holistic support to vulnerable families.

Network navigation

A new model, based on data collected from children of parents experiencing severe and enduring mental illness, presents key information about children's networks.[5] It found that networks are typically flexible and responsive to visible age-related needs, such as childcare and recreation, but less reactive to more obscured needs, such as assistance with caring for an ill parent, or help with basic household tasks, and flexibility and support with academic studies where home study is disrupted. This is relevant to chronic parental mental illness which can improve and worsen episodically over time, affecting children in ways that may be imperceptible to others.

Research has found that while young children may find themselves well-supported by social networks, older children, often acting as carers for their parent, may not be adequately supported.[5]

The research also found that children primarily rely on parents for support, even when those parents are unwell. Overall, support networks are often limited, with diminishing support over time.[6] This is likely a result of children appearing more capable and independent as they get older, and network members incorrectly assuming they need less help than they do in the light of hidden family needs. When support is lacking, either due to parental ill health in the moment or a lack of connections overall, other networks can step in to fill the gap if the need is identified. This is of crucial relevance for mental health and other professionals. The finding reinforced the need to stay attuned to ongoing and dynamic support needs of children in vulnerable contexts.

> **...it is also important for us to situate families and children in their own personal and social context... that includes friends, immediate and extended family, acquaintances and professionals**

Friendships are a vital source of support for children, especially providing recreational opportunities, but can also bring added stress. This is often related to the stigma of having a parent experiencing mental health issues. Children may experience bullying, or the disclosure of their private information by previously trusted friends. They respond in different ways to this negative experience, but a common occurrence is to become more guarded about what they share or avoid peer relationships altogether. Interestingly, many children highlighted the importance of pets – connections which offer non-judgmental companionship and a safe emotional bond.[6]

Some of these coping strategies can have negative knock-on effects, such as isolation or low self-worth and a lack of social skill development, particularly if the strategies become entrenched. This highlights the importance of professionals, including counsellors, to assist children to develop positive social coping strategies. The concept of 'network navigation' refers to a child's ability to manage and negotiate their relationships in such a way as to secure the instrumental and emotional support they need. This can range from practical help and access to resources to meet their basic needs, to friendship, trust, compassion and care. Time for recreation is also important.

Often, the role of network navigation is overlooked; interventions can conceptualise children as passive recipients of support and assistance. However, the research clearly highlighted that children are active navigators of their social networks, negotiating social relationships and working to meet their own needs.[6]

Role of professionals

Research underscores the importance of empowering children to build and maintain essential social connections through relational work. Talking therapy can play a key role in helping children to process and make meaning of negative experiences. Therapists can model healthy relationships and guide children toward positive connections, as well as help them develop appropriate help-seeking behaviours. Effective network navigation depends on a range of factors, including cognitive and emotional capacity, and the availability of alternative connections to fill gaps in their current support network.

Professionals are often acutely aware of the need for support in the families they work with and the issues children are facing. However, they face significant adversities, including limited resources and challenging working conditions. Further research shows that mental health and other professionals recognise a number of network-related issues affecting children of mentally ill parents. These include the impact of caregiving roles on the opportunity to engage with their own networks, the loss of social ties and the disruption that networks face during schooling transitions. Experts cite the importance of early identification of both the parental mental illness itself, and of the child as a dependent of someone suffering from mental health difficulties.[7] When this is done well, professionals can see opportunities to provide parenting support, assist with community integration, and provide clear, accessible information, as well as the opportunity for skills building, including prosocial behaviours and network navigation skills.

When professionals adopt a network-conscious approach that keeps all these factors in mind, there is potential to improve outcomes for vulnerable children affected by parental mental illness. However, several barriers hinder this, including difficulties in identifying need, poor communication between professions and heavy workloads. Research has identified factors to support network-conscious working, including staff training about the impact of parental mental illness on children, facilitating interdisciplinary communication, consistency in relationships, providing referral opportunities to specialist services, and focusing on preventative mental health care to address issues before they escalate into family crises.[7]

> **…'network navigation' refers to a child's ability to manage and negotiate their relationships in such a way as to secure the instrumental and emotional support they need**

……

How to do better

There are currently very few evidenced, effective interventions that target network concerns for children influenced by parental mental illness.[8] This is partly because interventions often fail to adequately conceptualise what they mean by terms such as loneliness, isolation and connectedness, which leads to unclear objectives and inadequate measurement of change. Successful large-scale interventions need to clearly define desired changes and understand how they intend to intervene. These methodological findings can be extrapolated from large-scale interventions to individual therapy interventions as well. It is worth considering what specific social changes would benefit our clients: More friends? Better trust in relationships? A good understanding of healthy social interaction? The ability to ask for what they need? By negotiating social goals clearly with young clients, we can help them to progress towards them.

The hope is that the research conducted with families affected by mental illness, and the professionals working with them, will equip mental health professionals to better identify, understand and address the social dynamics influencing the wellbeing of children of parents with severe and enduring mental illness. Network-conscious working can help us to enhance interventions and promote healthier support systems for children, improving their overall wellbeing and quality of life. Counsellors play a crucial role in helping children to develop network navigation skills, form healthy relationships and promote positive help-seeking behaviours that are likely to improve their future trajectory. Research elucidates some of the common barriers that counsellors are likely to face in practice, which we as a profession need to lobby against so that we can provide more effective and holistic family care. ■

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References

1 Brooks H, Bee P. Lovell K, Rogers A. Negotiating support from relationships and resources: a longitudinal study examining the role of personal support networks in the management of severe and enduring mental health problems. BMC Psychiatry 2020; 20: 50.

2 Nicholson J, Biebel K, Katz-Leavy J, Williams V. The prevalence of parenthood in adults with mental illness: implications for state and federal policymakers, programs, and providers. In: Manderscheid R, Henderson M. (eds). Center for mental health services. Maryland: Substance Abuse and Mental Health Services Administration; 2002 (pp120–137).

3 Reupert A, Mayber D. What do we know about families where parents have a mental illness? A systematic review. Child & Youth Services 2016; 37(2): 98– 111.

4 Tapias E, Coromina M, Grases N, Ochoa S. Psychological treatments with children of parents with mental illness: a systematic review. Child & Youth Care Forum 2021; 50(6): 1107–1130.

5 Nevard I, Brooks H, Gellatly J, Bee P. Modelling social networks for children of parents with severe and enduring mental illness: an evidence-based modification to the network episode model. BMC Psychology 2024; 12(1): 162.

6 Nevard I, Gellatly J, Brooks H, Bee P. Conceptualizing the social networks of children of parents with serious mental illness: a thematic analysis. Frontiers in Psychology 2024; 15. [Online.] https://tinyurl.com/yu226x2y (accessed 10 September 2024).

7 Nevard I, Brooks H, Gellatly J, Bee P. Socially oriented approaches to working with children of parents with severe mental illness 2024. [Manuscript submitted for publication].

8 Nevard I, Brooks H, Gellatly J, Bee P. Social network interventions for children of parents with severe and enduring mental illness: a scoping review 2024. [Manuscript submitted for publication].

Routine outcome measures

Alison Edwards reflects on her use of three well-known tools for measuring the effectiveness of counselling

I have worked as a school counsellor within educational settings for over 14 years, and would like to share my experience of using routine outcome measures with children and young people. Early in my career, I used the Young Person Core (YP-Core),[1] a 10-item measurement of psychological distress for children and young people aged 11 to 16, and the Strengths and Difficulties Questionnaire (SDQ),[2] a behavioural screening tool for two to 17-year-olds. I experienced anxiety when I started to use these outcome measures as to how the scores would change during counselling, and if that could be perceived as my failure as a counsellor. I was anxious about how much the school/agency would expect scores to change and whether young people would feel they had failed if their goals were not met. I spent much time in supervision exploring these anxieties. With experience, I now find measurements and goal setting to be such useful tools in the counselling room.

My first experience of using outcome measurements was as a social worker in Child and Adolescent Mental Health Services (CAMHS), where assessment scores were included in clinical reports. I do not recall any expectation to complete the assessment with clients in session or discuss the scoring with them. However, I decided early on to do so, to enable young people to see the purpose of measurements as a tool to record their therapeutic journey, rather than just a tick-box exercise. I shared the outcomes with the young person and asked if the measurements reflected how they were feeling. These measurements can be a useful tool for young people following a difficult period to quantify how they have been affected. The changed scores become validation of the progress they have made in processing their experiences in counselling.

When I worked with younger children, I used the SDQ measurement, which I introduced differently to the YP-Core. The YP-Core is for older children who can choose to complete the forms themselves or have me read each statement and then select an answer. In my experience, primary school aged children need more interactive ways to complete outcome measures. To complete the SDQ, I encouraged children to move to different parts of the room to represent their answers or use figures in a sand tray. I read *The Huge Bag of Worries*[3] and invited children to rate their worries as big, medium or small, relating this to the answers on the SDQ questionnaire.

> I no longer experience the same anxiety around using outcome measures as I did earlier in my career, and instead find them to be such useful tools in a counselling setting

Goal-based outcomes

I recently decided to invite young people to set goal-based outcomes (GBO)[4] consisting of statements about what they would like to happen as a result of attending counselling. These are scored to describe how close a young person is to reaching a goal. I experienced mixed results, with some young people completing the task with ease, while others required two sessions to set and score goals. Most students began with statements such as, 'I don't know' or 'My parent/teacher says…'. With encouragement, all were able to set at least two reachable goals for themselves. The section regarding obstacles to obtaining goals provided insights into possible setbacks. I listen to obstacles without trying to rescue, noting the young person's concerns. Obstacles outside the young person's control or that of the therapist were acknowledged – such as needing to move house or change school, teachers striking, climate change and war, while other obstacles were related to a lack of young person's motivation.

GBOs remain confidential unless I have the student's permission to put them into a report. YP-Core scores are given to the school to evaluate the service, and can be used as evidence to request further counselling sessions for a student.

There is a risk that goals may not be accomplished, and even the word 'goal' can be viewed in an educational setting as something to be achieved or failed at. I am conscious of my own 'goal': that counselling should not be perceived as a target to be achieved. To prevent this, I conduct regular reviews to acknowledge the client's journey – how far they've come and how far is still to be travelled. Reviews also provide an opportunity to discuss the working alliance, and what has been useful or not. In my experience, routine outcome measures provide a useful tool to enable these discussions to take place.

I no longer experience the same anxiety around using outcome measures as I did earlier in my career, and instead find them to be such useful tools in a counselling setting. ■

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References

1 CORE System Trust. YP-CORE [Online.] https://tinyurl.com/3zfnsktx (accessed 02 September 2024).

2 Anna Freud Mentally Healthy Schools. The strengths and difficulties questionnaire (SDQ) [Online.] https://tinyurl.com/42eznssd (accessed 02 September 2024).

3 Ironside V, Rodgers F. The huge bag of worries. London: Hodder Children's Books; 2011.

4 CORC Child Outcomes Research Consortium. Goal based outcomes (GBO). [Online.] https://tinyurl.com/h22ps9af (accessed 03 September 2024).

Unmothered

Elizabeth Holt explores the impact of turbulent relationships with mothers and the development of the mother wound

'*Unmothered* (adjective): deprived of a mother: MOTHERLESS'[1]

Every human being has a mother, whether a strong relationship is established with them or not. As counsellors and psychotherapists, we will encounter individuals who bring complex and turbulent relationships with their mothers and mother substitutes into the therapy space. Societal norms, conditioning and the therapist's personal experience of familial bonds, including being parented and/or being a parent themselves, have the capacity to influence our approach to therapy. Although difficulty in the mother-child relationship can be an isolating hurt carried and held in silent shame, typing the phrase 'mother wound' into Google generates 140,000,000 results in 0.63 seconds, indicating that those experiencing difficulties with their maternal relationships are far from alone after all.

Through my personal experience and the shared experiences of clients, it is apparent that therapists, peers, friends and other professionals can greatly misjudge the severity of the disruption to the client's sense of self, the loneliness of not being understood, and the feeling of judgment for choosing to estrange from a mother following years of abuse. Often, the 'unmothered' are met with such phrases as, 'You only get one mother', 'She is still your mum', and, 'You'll miss her when she's gone'. This article seeks to shine a light on a hidden truth and provoke consideration of kinder ways of supporting people to heal from the mother wound in the safety of the therapeutic space.

Attachment theory and the mother wound

Psychoanalyst John Bowlby developed an explanation for how bonds were formed between primary carers (usually mothers) and their children, and how these bonds, or attachments, were structured in the mind of the developing child. He concluded that the primary carers' role was to create safety so that the child could form what is referred to as a 'secure base', that is, a space of safety that the child knows they can return to for consistent, dependable care in order to thrive. Bowlby and colleagues also explored the consequences of a secure base not being established, where instead an insecure attachment is developed. In instances where the child developed an insecure attachment with their mother, they experienced loss and grief.[2]

> The child struggles to believe that their caregiver is flawed and instead conclude that they are difficult to love

Attachment research suggests that our relationships and ability to explore life's opportunities as we grow are informed by how we have attached, or not, to our primary caregiver, typically the mother.[3] Therefore, children who have not developed a secure attachment are more likely to struggle with attachments in other close relationships and have it impact their quality of life. Developmental psychologist Mary Ainsworth and colleagues elaborated on Bowlby's research by establishing a method of observing how a child interacts and demonstrates their attachment style with their primary caregiver. Ainsworth's famous 'strange situation' experiment identified three attachment styles: secure, avoidant and ambivalent.[4]

Those who identify as unmothered are likely to fall into the insecure attachment categories of avoidant, ambivalent, or, (later added) disorganised. For example, a young child with an insecure ambivalent attachment to their mother will be clingy and not play or explore in her presence. The child may become distressed when the mother leaves the room, yet they are still distressed upon her return, rather than soothed by her being there. The 'mother wound' is a psychological phenomenon classed as an attachment trauma, which leaves children with a sense of confusion where they question their self-worth, worthiness of care from their mother, and hold a general feeling of unlovability and abandonment.[5] The child struggles to believe that their caregiver is flawed and instead conclude that they are difficult to love. As psychologist and author Shahida Arabi states, 'A child that's being abused by its parents doesn't stop loving its parents, it stops loving itself'.[6]

Growing in the dark

Some children grow in dark shadows created by an abusive home life, or maternal abuse of alcohol or other substances. They find themselves caught in the chaos at home, then head off to school as if nothing has happened. Despite their best efforts to mask any signs of distress, they may find themselves reprimanded for being tired or distracted, with no one knowing – or bothering to find out why – the real reason why. Abuse and addiction have a powerful and indiscriminate impact, destroying lives without hesitation. For children, who are still forming their identity and sense of self, the influence of a parent is crucial. But when addiction and neglect take over, the secrecy and hurt that follow can deeply distort this development.

As adults, we can understand that the issues of the parent are not a reflection of the child and nor are they caused by the child. Yet, the guilt and shame that young people can carry as a result of family difficulties can be damaging, with children blaming themselves or carrying the guilt of not being 'good enough'. Within the stories that I have been privileged to hear, there appears to be a theme: 'If I am good enough, then she/he/they will stop drinking/shouting/taking drugs'; which also translates into: 'She/he/they drink/shout/take drugs because I am *not* good enough'. The sense of shame a child internalises because of their environment is often unsaid and unseen, with external shaming then adding to it. Societal expectations and assumptions demonstrated through thoughtless comments can shift responsibility, and sometimes blame, away from the mother and onto the child.

The card shop scenario

Mother's Day, which is also referred to as the Christian celebration of Mothering Sunday, falls annually on the fourth Sunday of Lent, usually in March. The occasion is ordinarily celebrated with children gathering cards, flowers and gifts to display their appreciation towards their mothers for all that they do for them. Mother's Day is particularly uncomfortable, sometimes outright painful, for those who, for whatever reason, do not have a mother, or have a particularly difficult relationship with her, and it becomes another day in the silent calendar of grief. When society depicts an image of the mother as an infallible human with the capacity to love wholeheartedly and unconditionally, it is hard for those who feel unmothered to stand in a card shop or go anywhere near social media, and not feel like they did something wrong and are unworthy of such love.

In search of the 'perfect' Mother's Day card, a young person might look for something more aligned with their experience, something more appropriate which would read, 'You regularly weren't there for me, you were usually drunk and abusive when you were, you hurt me, and I still love you (or don't). Happy Mother's Day.' But, of course, such cards aren't available, so young people might instead select the plainest card they can find with a pretty picture and the message 'this card is blank inside' before exiting the card shop as quickly as possible. There is poignant symbolism in the blank card, a physical display of the loss experienced in place of celebration, and a literal representation of absence and words unspoken. The void mirrors the loss of the maternal figure, and captures the missing memories and the unfillable hole. As a counsellor, I have heard multiple versions of what I now refer to as 'the card shop scenario' from clients who have stoodin a card shop wishing they had the kind of mother described in the greeting cards, with 'If mothers were flowers, I'd pick you' and, 'Thanks for always being there for me when I needed you' making particularly difficult reading. Each story is unique, yet they share a similar, consistent thread of shame and loss – often the loss of what never was.

> …I have heard multiple versions of what I now refer to as 'the card shop scenario' from clients who have stood in a card shop wishing they had the kind of mother described in the greeting cards

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In the therapy room

Upon entering the counselling profession, I recall being told by a tutor, 'We are sent the clients who we need to meet.' While it seemed odd at the time, it has rung true. My client work has been fulfilling, challenging, invigorating, insightful and occasionally a little overwhelming (and everything in between), and I have met myself more than once. I have encountered unmothered people who seek therapy because of the wounds of a disrupted or non-existent relationship with their mother, and the way in which they have felt about themselves as a result. For adults and young people alike, it can be all too natural to fall into familiar patterns, letting toxic relationships repeat the pains of the past, and selecting people who treat them how they believe they deserve to be treated, based on their earliest relationships with their mothers.

It can be helpful to explore how clients experience shame and work with it in the safe, therapeutic space. For some, sessions may be the only place where they have been able to unpack the anger and resentment they hold towards their mother. Therefore, it is crucial that we hold our own judgment or difficulty with the content, whether it resonates or creates dissonance with our own experience, so we can stay with the client and guide them through the impact on their sense of self. There may be a temptation, for some counsellors, to encourage clients towards resolution, reconciliation, or forgiveness, or to let whatever it is their mother did in the past go. It takes courage for clients to speak their truth, and we must meet them where they are at. Healing often moves in layers, rather than following a linear process, especially when it comes to childhood trauma. Clients require acknowledgement, stabilisation and coping mechanisms which replace unhealthy internalised messages with healthier, kinder ones.

By recognising how our experiences shape us, we can create more choices for ourselves and decide who we want to become. Awareness brings with it the opportunity to consciously change the trajectory of what research suggests is inevitable for those who are unmothered. We can support these clients to work with feelings of isolation and step out of the shadows of shame that have been cast upon their lives. ■

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References
1 Merriam-Webster. Online dictionary. Unmothered. [Online.] https://tinyurl.com/4vx59bvj (accessed July 2024).
2 Bowlby J. Attachment and loss. Volume 1: attachment. London: Random House; 1969.
3 Bowlby J. Attachment and loss. Volume 2: separation: anger and anxiety; New York: Basic Books; 1973.
4 Ainsworth M, Blehar M, Waters E, Wall S. Patterns of attachment: a psychological study of the strange situation. New Jersey: Erlbaum; 1978.
5 Webster B. Discovering the inner mother: a guide to healing the mother wound and claiming your personal power. Harper Collins; 2021.
6 Arabi S. Becoming the narcissist's nightmare: how to devalue and discard the narcissist while supplying yourself. CreateSpace, South Carolina, USA; 2016.

Therapeutic integration

Stuart Ralph balances behavioural techniques and depth therapies, in a truly integrative approach to supporting teens with OCD

Obsessive compulsive disorder (OCD) is a condition characterised by ego-dystonic thoughts (obsessions) and behaviours (compulsions) that aim to reduce the emotions and obsessions. Mainstream psychiatry over the last 50 years has considered anxiety to be the driving force for OCD,[1] until more recently when other emotions, such as disgust, guilt and anger, were also acknowledged. Freud made this distinction well over 100 years ago, stating that obsessions could be accompanied by a range of emotions, whereas phobias appeared to rely solely on anxiety.[2]

The aetiology of OCD remains unknown, and it seems that factors vary between clients. Nature explanations have found a link to genetics and brain function,[3] while nurture explanations suggest that between 30% and 82% of people with OCD have experienced trauma.[4]

Treatment

OCD is arguably one of the most researched mental health conditions, with over 40 years of research and more than 35 randomised control trials (RCT) on exposure and response prevention therapy (ERP). ERP sits under the cognitive behavioural therapy (CBT) umbrella and works to varying degrees, but is no panacea. The goal of ERP is to move towards the obsessional fears and reduce compulsions. Clients have learned, partly through operant conditioning, that compulsions keep them safe. So, as the compulsive behaviours gradually decrease, they start to learn they are OK without them, and their symptoms reduce. This process was traditionally called 'habituation', the process whereby we habituate so that anxiety reduces over time. Some therapists prefer inhibitory learning, which suggests we learn safety in a way that inhibits prior learning. Using this method, I have seen clients go from spending hours carrying out compulsions, stuck in their room, to going to university and pursuing their goals. For ERP to help, the client needs to be motivated. At times, this can be a hard sell. For me, that's where acceptance and commitment therapy (ACT) can help.

Acceptance and commitment therapy (ACT) is considered a third-wave CBT treatment, and has a strong evidence base for the treatment of OCD.[5] It increases psychological flexibility; much like being flexible in the body prevents muscle and ligament tears, being flexible in the mind prevents mental tears. There are certain ACT skills that can increase cognitive defusion, which is the ability to see thoughts as just thoughts and bring the client into present moment awareness. These skills can make ERP more palatable and give the client skills to deal with rumination, a common mental compulsion of OCD. People with OCD typically overvalue their ideation, believe the obsessions and get pulled into compulsions that draw them into an abyss of experiential avoidance, diminishing their quality of life. Using ACT, I empower clients to refocus on things that matter to them, therefore reducing experiential avoidance and building a life of meaning for my client. ERP and ACT are the foundation of my work with teens with OCD.

Depth versus directive

Directive therapists may say that we do not need to go deeper than tackling the symptoms. I see their point, but would argue that symptoms can be signposts to older pain for some clients and this is where relational depth work can be helpful. We see this in the statistics that suggest up to 82% of OCD patients have experienced trauma.[4] Trauma can be directly treated alongside OCD, or prior, as sometimes the trauma can block the path to treating OCD. If there is no trauma, then sometimes the best way to do relational depth work is to firstly manage the symptoms – deal with the fire, and then rummage through the ashes for any embers. If we see OCD as a defence, then dealing with the symptoms should reduce this, allowing relational depth work to happen.

> ...sometimes the best way to do relational depth work is to firstly manage the symptoms – deal with the fire, and then rummage through the ashes for any embers

I sit with a foot in both camps – finding the potential root cause to work through it, while tackling the learned behaviours of OCD. I hold the root cause loosely because sometimes nothing can be identified for sure, but it can help the client piece their story together and give them a reason for their symptoms, which can be helpful for some. In 2022, I published a case study looking at a single case from the ETHOS trial, a randomised control trial investigating the effectiveness of brief humanistic counselling within a school setting, of a teen experiencing OCD using brief humanistic counselling.[6] I found that the intervention allowed them to explore traumatic memories and build peer relationships. However, enabling compulsions in sessions was not controlled, which may have had a negative impact on outcomes, furthering my belief in the importance of therapeutic integration. I wish more therapeutic purists would see the benefit of integration, and the value of alternative theories. We need many tools to climb Mount Everest, not just one.

Going deeper

I increasingly use compassion-focused therapy (CFT) with young clients with OCD to target the inner critical voice. Many have developed a sense of self as bad or beyond repair. Intrusive thoughts can often be dark in nature, with taboo themes making sufferers feel confused, lost and isolated. OCD is sometimes called 'the secret illness' because people often suffer in silence, deeply afraid they will be seen as troubled or unwell and kicked out of the tribe. Research suggests that it takes an average of 14 years to get help.[7] I hope that with the increase in mental health awareness, children are less afraid of sharing their troubles. I use compassion-focused chairwork, inspired by Gestalt therapy, to help young people 'put' parts of themselves in different chairs and give voice to those parts, revealing useful insights that can be brought into consciousness for discussion, separately and in dialogue with each other. We introduce the compassionate part of the client to support them in the presence of the inner critic. Depending on age and openness to creativity, I have found using Play-Doh productive. The teen is invited to mould different parts, such as the OCD itself, the inner critic and the compassionate self, then allow the Play-Doh parts to 'speak' with each other, encouraging the compassionate part to talk to the parts that are causing pain. The teen may have suffered for many years with an internal bully. Changing this pattern of vicious dialogue to one of compassion can help them to respond in healthier ways.

Sandplay

More recently, I completed a diploma in integrative sandplay, based on Jungian philosophies using symbols (miniatures) in the sand to bring the unconscious to life. This helps clients to make the unknown known, and be able to work with it. Over time, I have observed sand trays go from chaotic and rich with intense emotions, to orderly and calm. During my training, I created a tray that meant nothing to me on a conscious level, yet I could not sit next to it as it made me squirm. Through processing, it began to make sense, which illustrated the power of letting the unconscious speak. As Jung said, 'Often the hands will solve a mystery that the intellect has struggled with in vain.'[8]

In OCD work, I have found several uses for sandplay beyond the original purpose of helping young people connect with their inner symbolic world. Sand is sensory which can help soothe and regulate anxious teens. It does not require speech which takes the pressure off – although speech can help. Sandplay allows the unknown to come forth and be worked through, allowing the unspeakable to be spoken through symbols, which are sometimes a safer medium than language. Inviting teens with OCD to create a sand tray about their OCD allows them to see it in physical form, which can act as cognitive defusion. As they add new symbols to support others in the tray who are scared or anxious, for example, dialogue can open up about recovery.

> **Reducing symptoms and doing relational work can feel like an either/or choice. I see these approaches not as separate and opposite, but as counterweights that create balance**

……

Parents role in recovery

OCD can be seen as a family problem, functioning like a black hole that pulls in everyone close to it, at least everyone who isn't anchored to something sturdy. I have seen countless times how the symptoms of OCD have affected the whole family, exhausting relationships and straining wider systems around the teen. Parent-child relationships can get combative. Parents can get unwittingly and unknowingly coerced into their child's compulsions, accommodating the OCD behaviour. They do this because they care, yet accommodating their child's compulsive behaviours has a paradoxical effect, as it maintains them. Eventually, most parents hit a wall and relationships become strained. Sometimes, having the parent in the therapy room can be helpful (with the teen's permission). If indicated, I sometimes refer on to a family therapist to help the family navigate their dynamics, as the issues within the relationship can be a hindrance to individual OCD work.

I use the principles of Supportive Parenting for Anxious Childhood Emotions (SPACE) to help parents navigate their child's OCD. This systematically reduces accommodations and increases support, so that the child can feel more emotionally held by their parents. SPACE is typically used when the child refuses treatment and the therapist works solely with the parents.

Conclusion

Treating OCD is complex and there is so much more to learn. Reducing symptoms and doing relational work can feel like an either/or choice. I see these approaches not as separate and opposite, but as counterweights that create balance in the work. Understanding the nuances about how OCD can manifest, and applying a truly integrative therapeutic approach, helps teens face their fears, reduce compulsions, and live a rewarding life. It is a joy to accompany them from doubt to direction, a battle all teens face, but especially those affected by OCD. ■

Stuart Ralph MBACP (Accred) is an integrative counsellor and psychotherapist working with children and young people. He is the founder of the weekly podcast The OCD Stories and co-founder of The Integrative Centre for OCD Therapy. **www.integrativecentreforocd.co.uk**

References

1 The Polyphony. Guilty obsessions. [Online.] https://tinyurl.com/dbkvjvm7 (accessed 15 August 2024).

2 Freud S. Obsessions and phobias. Place of publication: White Press; 2014.

3 OCD and the brain. Explore what we currently know about the OCD and the brain. [Online.] https://tinyurl.com/3xf5zr8t (accessed 17 August 2024).

4 Dykshoorn K. Trauma-related obsessive–compulsive disorder: a review. Journal of Health Psychology and Behavioral Medicine 2014; 2(1): 517–528.

5 Soondrum T, Wang X, Gao FA, Liu Q, Fan J, Zhu X. The applicability of acceptance and commitment therapy for obsessive-compulsive disorder: a systematic review and meta-analysis. Journal of Brain Sciences 2022; 12(5): 656.

6 Ralph S, Cooper M. Brief humanistic counselling with an adolescent client experiencing obsessive-compulsive difficulties: a theory-building case study. Journal of counselling and psychotherapy research 2022; 22(3): 748–759.

7 Ziegler S, Bednasch K, Baldofski S, Rummel-Kluge C. Long durations from symptom onset to diagnosis and from diagnosis to treatment in obsessive-compulsive disorder: a retrospective self-report study. PLoS One Journal 2021; 16(12).

8 Jung CG, Adler G, Hull R. Collected works of CG Jung Volume 16. Practice of psychotherapy. New Jersey: Princeton University Press; 1992.

Requires improvement

Katie Parks reflects on the impact of Ofsted inspections, and shares her hope that improvement is on the horizon

In April 2024, I published a blog outlining the initial fallout I observed from an Ofsted inspection, reflecting on my role in supporting the school's process and recovery.[1]

Six months on, the Ofsted report is in the public domain, and I am exploring how the school staff and wider community reacted, what lessons I have learnt as a school counsellor, and what I hope will be helpful to share with the counselling community. In doing so, I invite you to reflect on your work setting and the possible impact of experiencing something similar.

I work in a large, inner-city primary school in East London, and we had been expecting an Ofsted inspection. I am not new to the process, having been part of 11 inspections during my 33-year career in education, the last four in my role as school counsellor. However, this recent inspection left me feeling not good enough, in a way that previous ones, rated 'Good' had not. This time, Ofsted downgraded the school from 'Good' to 'Requires improvement', which impacted staff enormously and left me acting as a container for their emotions. I became ill and realised I was holding so much anger, mine as well as theirs. Recognising this was helpful and made me realise more than ever the importance for self-care.

School Ofsted inspections usually take place every four years, with schools graded 1: Outstanding; 2: Good; 3: Requires improvement, or 4: Inadequate. Many parents rely on Ofsted ratings to help them choose a school or nursery.[2] Inspectors judge the school's overall performance, quality of education, pupil behaviour and attitudes, staff development, calibre of leadership and management, and the effectiveness of safeguarding procedures. The final published report gives the school one overall grade.

Importance of psychological safety

Being part of an organisation that encourages staff to be open, ask for help, challenge ideas, and take risks without the fear of being punished has been foremost in my mind after the most recent inspection. Psychological safety can be defined as the absence of interpersonal fear, allowing people to perform their best at home, school and work.[3] It nurtures an environment where people feel encouraged to share creative ideas without fear of personal judgment.[3]

In the counselling space, ensuring our clients feel safe is central to building an authentic relationship and enabling them to begin to trust us in the therapeutic process. Within a school context, this extends to staff, and now, more than ever, we are aware of the need to support wellbeing in organisations. As therapists, our training and ethical guidelines encourage an openness to criticism, learning and professional development, enabling us to reflect on how we can invite similar growth in our clients. The question that has been in the forefront of my thinking is how psychologically safe teachers feel, and how they can perform at their best if they fear judgment. Comments shared with me by staff show how they are struggling with the impact of the inspection: 'I still feel angry and upset, it knocked my confidence.' 'I'm more nervous now because of it.' 'It has given me more anxiety.' 'I still think about it, they are going to come back.' 'It feels like there is a lot of tension, in the aftermath of what have they done to us.'

> Ofsted [have] scrapped the one-word grades for school inspections... [and we] can only hope that the new inspection framework will enable a more progressive, healthy and supportive school environment

I asked staff how they would like the inspection processes to be conducted, and was struck by the desire for a supportive relationship, akin to what we foster as therapists. Staff said: 'They should be supportive rather than tarnishing schools with a label.' 'They should listen to us. The process needs to be more supportive.'

> ...[psychological safety] nurtures an environment where people feel encouraged to share creative ideas without fear of personal judgment ... Ofsted inspections do not foster psychological safety where people can learn and grow together

In my experience, Ofsted inspections do not foster psychological safety where people can learn and grow together. The act of grading creates anxiety, distress and pressure on the workforce where 'at least once a month, 83% of education workers feel a sense of dread relating to work. For one-third of workers, this is being driven by a fear of being overwhelmed due to unrealistic expectations.'[4]

During the aftermath of inspection, the school I work in has widened its offer of staff supervision. The Mental Health Support Team (MHST) has created additional time for staff support, while frequent reminders have been issued about the employee assistance programme (EAP) as part of the wellbeing offer. The school recognises the importance, especially now, in building resilience within the team; how else can they be expected to be an emotional container for their pupils?

Response from the wider community

The school provides education for pupils and an emotionally safe space in a wider social context of deprivation. The relationship with parents is complex. Often, they struggle to engage with staff and withdraw or disengage from other services. Since the publication of the Ofsted report, the school has received mixed responses, with parents becoming challenging to staff or quoting parts of the report on social media, at the school gate, or in their correspondence with the school. Trying to connect with our wider community has always been tricky, but since the publication of the report, it has become more of a challenge. I wonder how Ofsted reports inform parents' decisions about which school to send their children to, and how the recent inspection of the school I work in will affect our intake of students.

Who judges the judges?

Julie Waters, the sister of Ruth Perry, a headteacher who died by suicide following her school being downgraded by Ofsted inspectors, has been publicly critical of the current inspection framework. She asked, 'How many more teachers will suffer from an inherently flawed, badly-run inspection process? How many more children will lose another dedicated headteacher to a forced resignation, a nervous breakdown or worse?'[5]

The current system of inspection is not only countertherapeutic, it is out of line with how educational establishments operate. Ofsted uses a problem-focused approach to evaluate schools, focusing on the issues and applying one word judgment. I wonder how it would be for a therapist to be told they 'require improvement'? What about a child? Many school staff would agree that there needs to be a better monitoring process that fosters learning and development. Thankfully, things may be about to change. At the start of September, Ofsted announced that they had scrapped the one-word grades for school inspections with immediate effect.[6] We can only hope that the new inspection framework will enable a more progressive, healthy and supportive school environment, where teachers and pupils can grow and develop. If we were to judge Ofsted in the way that they have judged schools to date, I think we would mostly agree that they require improvement. Hopefully, those improvements are on the horizon. ■

Katie Parks MBACP (Accred) is a school counsellor and Thrive Lead in a large inner-city primary school in East London. She previously worked as a teacher.

References

1 British Association for Counselling and Psychotherapy. Ofsted and the need for resilience in the face of being downgraded. [Online.] https://tinyurl.com/2ru939ar (accessed 3 September 2024).

2 BBC. What does Ofsted mean and what are the ratings? [Online.] https://tinyurl.com/7jdbrtdd (accessed 3 September 2024).

3 McKinsey and Company. What is psychological safety? [Online.] https://tinyurl.com/ksmnbf8c (accessed 3 September 2024).

4 Schools Week. How stressed are teachers compared with other professions? [Online.] https://tinyurl.com/5396d6z9 (accessed 3 September 2024).

5 Schools Week. Perry's sister tells NEU: let's reform not abolish Ofsted. [Online.] https://tinyurl.com/2239hckh (accessed 3 September 2024).

6 BBC. New Ofsted school grades will not confuse parents – PM [Online.] https://tinyurl.com/24h9pd58 (accessed 19 September 2024).

News

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

Languaging suicide

The NSPCC's *Why Language Matters* blog series aims to improve child protection and safeguarding through language. In a recent post about suicide, the children's charity states that language which increases the stigma around suicide makes it harder for young people who may be struggling with suicidal thoughts or feelings to express them and seek help. Stigmatising language can also make it harder for others to speak openly about their experiences, further complicating the grief of anyone impacted when a young person dies by suicide.

Describing someone as 'committing' or 'trying to commit' suicide implicitly accuses them of having done something wrong. It refers to a time when suicide was illegal and anyone who survived an attempted suicide could be imprisoned. Suicide was decriminalised under the Suicide Act (1961), but the language lingers.

Case reviews highlight how feelings of failure and rejection are warning signs of teen suicide. For a young person who has tried to end their life, talk of a 'failed' attempt may exacerbate any pre-existing feelings of failure. Similarly, phrases such as 'unsuccessful' or 'uncompleted' suicide might lead them to associate dying by suicide with 'success' or 'completion', while surviving suicide would be deemed 'unsuccessful' or 'incomplete.' The NSPCC warns that misusing the language of achievement could implicitly encourage future suicide attempts. They also caution against language which minimises or trivialises the level of emotional distress that a young person is experiencing or using euphemistic language.

https://tinyurl.com/5n6udfpf

Artificial intelligence

A study by children's charity Barnardo's has highlighted uncertainty about children's use of artificial intelligence (AI). Members of the Online Safety Programme engaged with over 500 children and young people aged between 10 and 14, 101 parents and 63 teachers. Young people described AI as useful and fun, but also highlighted concerns about how it can be used to manipulate them or invade their privacy. Sixty-three per cent of young people said they learnt about AI from social media and 54% would like to learn more. Most (82%) felt that their parents knew nothing or not much about AI and 93% of parents said they have concerns about their children using it.

Barnardo's is calling on the Government to consider how we can best educate and guide young people in their experience of AI, while ensuring their safety and wellbeing online. The charity also wants to offer support to parents and training to teachers and other professionals.

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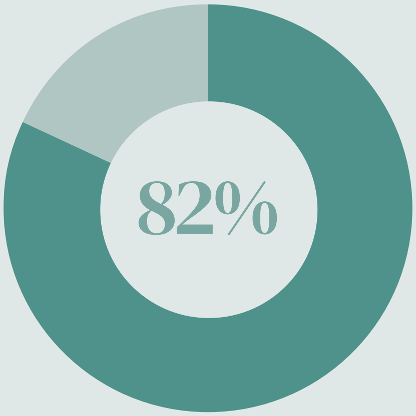


82% [of young people] felt that their parents knew nothing or not much about AI

The internet is not harmful

MQ Mental Health Research, in collaboration with Melbourne University, Harvard University and the Oxford Internet Institute, conducted a review of existing research evidence into positive and negative effects of the internet on youth mental health. The comprehensive review found that extensive internet use is not harmful for young people, but rather it is the type of online experiences and what they are replacing that impact mental health and wellbeing. For example, if internet use disrupts sleep, school and social interaction, there can be a negative impact on cognitive function, emotional regulation, academic performance and social relationships.

However, positive online activities can also replace unhelpful offline ones, such as rumination, loneliness, negative emotions or behaviours. If young people have a diverse and fulfilling life offline, their online world is likely to be an extension of this. If their offline world is not fulfilling, they may use the internet to replace what they are missing, which could have a negative impact.

https://tinyurl.com/2a4dkw33

Their things matter

The practice of asking young people in care to move their belongings in a bin bag or throwing away their belongings without their consent is still common, despite previous campaigns. Now, the National Youth Advocacy Service (NYAS), a charity that supports care-experienced children and young people, is running a campaign, called My Things Matter, asking local authorities to pledge never to ask a young person to move their belongings in a bin bag or throw away a young person's belongings without their consent. They have asked local authorities to work with children in care to ensure they feel supported when moving placement.

The campaign has also teamed up with social enterprise Madlug, set up by a youth worker in 2015, which donates a travel bag to a child in care for every bag it sells.

It is now donating bulk orders of free bags to local authorities that have signed a pledge. Nine of the 22 local authorities in Wales have committed to the campaign pledge since it launched in 2022. In an interview with the BBC, Welsh Chairman of the Campaign Advisory Group at NYAS, Jay Jeynes, who is care-experienced himself, has urged the remaining 13 Welsh local authorities to commit to the pledge.

https://tinyurl.com/yc8mc5dk

More help needed for under-fives

The NSPCC has called on the Government to invest in early years services after statistics revealed that almost 40% of referrals made by their Helpline to local services were aged under five. Government data shows that children aged five and under are particularly vulnerable to serious cases of abuse and neglect. In the past year, almost 200 died or were seriously harmed in England, representing almost half (48%) of all serious cases.

The most common concern highlighted by NSPCC statistics for children under five was neglect, with 5,000 children referred to police and social care services because their basic needs were not being met. The second biggest concern was physical abuse, with children under five reporting being smacked, hit, punched, kicked, physically punished and having non-accidental injuries. This abuse resulted in 2,344 referrals for children aged five and under.

A spokesperson for NSPCC highlighted that babies and young children are completely reliant on their parents and carers to meet their needs, and are less likely to ask for help when those needs are neglected. Pre-school children under five are particularly vulnerable because they are least visible to professionals.

https://tinyurl.com/3txdtzw8

Postcode lottery for CYP mental health

A report from the Education Policy Institute (EPI) found significant gaps in mental health support for young people across England and a rise in the number of young people reaching crisis. The report highlights a 'postcode lottery' indicating substantial variation in the range of services available, and a lack of awareness of the service landscape in local authorities and NHS Trusts. Half of England did not have targeted services for LGBTQ+ young people, and two thirds had no targeted services for ethnic minority groups, or other underserved groups such as refugee and asylum-seekers, or care-experienced young people.

Data from NHS England show a rise of 20% of young people aged 11 to 25 admitted to hospital for mental health reasons between 2017 and 2023.

The EPI has called for the Department for Health and Social Care (DHSC) to explore quality and accessibility of specialist and non-specialist services supporting young people's mental health, and ensure services are delivered in relevant settings, including schools. It also highlighted a need to improve understanding of demands for services, with a particular focus on specific groups such as girls and young women, ethnic minority groups and LGBTQ+ young people.

The EPI has called on NHS England to address persistent weaknesses in provision, and outline best practices for stakeholder collaboration, addressing fragmentation across commissioners and providers.

It is hoped that the rollout of Young Futures Hubs, a pillar of Labour's youth mental health support programme, will address gaps in provision and integrate existing open access services.

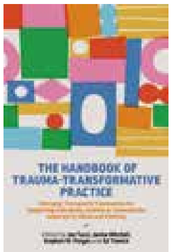
https://tinyurl.com/349ky4pc

Reviews

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

The Handbook of Trauma-Transformative Practice: emerging therapeutic frameworks for supporting individuals, families or communities impacted by abuse and violence

Joe Tucci, Janise Mitchell, Stephen W Porges and Ed Tronick (eds)
Jessica Kingsley Publishers 2024
ISBN 978-1787755772



This weighty tome is not for the faint-hearted! Consisting of 16 academic essays, it begins with a chapter authored by the four renowned international editors, and is tied together by two of them in a final chapter. At the end of each essay, the editors offer knowledge and practice reflections which would work well as discussion starters within services about how to move from trauma-informed towards trauma-transformative work. For research purposes, the many references at the end of each chapter would also be valuable.

The book looks at how to progress from trauma-informed work, which started around 20 years ago, to further support individuals, families and communities affected by interpersonal and intergenerational abuse. Clear examples show how trauma impacts the body, brain and whole communities, and how this can begin to be healed, considering advances in neuroscience and the importance of social communication. In particular, the mother-child relationship is highlighted, with an informative description of attachment, including key predictors of disorganised attachment. The authors consider how the loss of key relationships where violence has occurred impacts children and whole communities, through damage to ancestral or cultural links.

The chronic nature of trauma is highlighted, with authors explaining that the event itself is not the trauma, trauma is the victim's internal experience. The importance of meaning-making is considered, not just through verbal storytelling, but also through examining bodily responses to understand neurosomatic levels of trauma. The victim's experience of shame, shaped by evolutionary processes, is viewed as being at the intersection of brain-body systems and is important enough to run through various chapters.

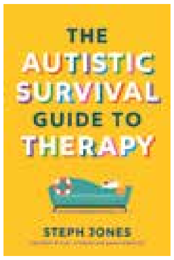
While much of the book is academic, there are occasional illustrations which I found helpful. For example, the one illustrating how to build self-compassion to facilitate the wisdom and courage needed to turn away from distress towards hope. Another, in the final chapter, is a table showing eight categories of trauma, with examples of each. Some case studies are included, showing how to make the paradigm shift from being trauma-informed to trauma-transformative, including how to support parents and carers to help children to begin to restore trust in themselves, their parents and caregivers, and other significant adults, including therapists. I liked the way that the book shifts easily from world views of trauma in whole aboriginal communities, to individuals in the care system, to children displaying sexually harmful behaviour and more.

Ending with 12 discrete but integrated core dimensions needed for trauma-transformative practice, from safety, to compassion, to hope and beyond, the message is to involve those with lived experience as much as the individuals and organisations who support them, so that from the profound scars of interpersonal violence, sustained healing may be allowed to occur.

Helen Hardacre BACP (Accred),
counsellor and EMDR therapist

The Autistic Survival Guide to Therapy

Steph Jones
Jessica Kingsley Publishers 2024
ISBN 978-839977312



Steph Jones, former journalist-turned-therapist, is a late-diagnosed autistic woman, and an autism and ADHD assessor. She draws on her personal and professional experience across the board and writes with wit, warmth and wisdom. Writing in the introduction, Jones says that this is the book she wishes existed 20 years ago, before her personal therapy, therapy training and autism diagnosis. As a therapee (her word), she visited nine different therapists, none of whom suggested she might be autistic and all of whom suggested various other (mis) diagnoses ranging from trauma, anxiety, bipolar and personality disorder. She shares an 'alarming but true fact' that many late-diagnosed adults don't discover they are autistic until the sh*t hits the fan – a statement that many readers will relate to.

This 'autistic consumer's guide' to therapy follows Jones' personal therapeutic journey, providing insight into the mental health of a neurodivergent operating system, and helping to differentiate between helpful and harmful therapy. It is divided into eight chapters: Myths, misdiagnosed and misunderstood; Trauma; Do you see what I see?; Problems we might encounter and why traditional therapies fall short; Red flags and red herrings; Therapeutic concepts; Choosing the right therapy and therapist; and, So does neurotypical therapy work for neurodivergent brains?

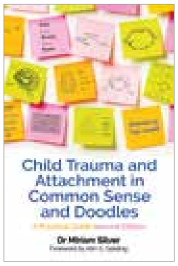
The book is packed with relatable statements, many of which are both alarming and uncomfortable. Jones confronts the statistics – 58% of people in mental health inpatient facilities are autistic (NHS England, 2022) (p125); 66% of autistic adults have contemplated suicide (South et. al., 2021) (p125), and 71% of young people with autism meet the criteria for one or more mental health disorders (Simonoff et. al., 2008) (p127). She calls out inadequate therapeutic practice, which she blames, in part, on limited or non-existent training in neurodiversity. I wonder how much autism education was included in your therapy training and whether that has changed in more recent years? She advises therapees about how to spot 'red flags' in ableist therapists, such as being misattuned, minimising, not listening or outright denying signs of autism, as well as those therapists who insist they are right and know best – Jones met nine of them and has drawn on her experience to create fictional bad therapist Veronica, and her fictional therapy encounter, with Jones as client, threads through the chapters. I thought this story would work as a standalone pocket-sized book, preferably illustrated as a graphic cartoon, to illustrate harm in therapy and what not to do. Also included in each chapter are quotes from other therapists and clients about their own experiences – good and bad. This book is full of personality and emotion. 'Really?' I imagine the uneducated, fictional character questioning me, 'Aren't autistic people cold and affectionless?' It made me smile, tear up, nod in recognition, want to read it again, and recommend it to every single client and therapist I know. Bravo Steph Jones.

Jeanine Connor MBACP, psychodynamic psychotherapist and editor of this journal

Child Trauma and Attachment in Common Sense and Doodles: a practical guide (second edition)

Miriam Silver

Jessica Kingsley Publishers 2024
ISBN 978-1839979125



I have read several books on attachment and trauma which can feel quite heavy given the complexities of the topic. However, this book offers an accessible well-written account of child trauma and guidance on reparative work. For those who are already well informed on the topic, I would say this will recap on current knowledge, but Silver also includes subjects such as sexual exploitation and working with asylum-seeking children.

The 'doodles' don't dominate this book, but every few pages, they are included to demonstrate a point or explore it further. These could appeal to visual learners to help understand certain concepts.

This book inspired me with ideas on how I might teach child trauma to students as the doodles could be brought to life in an interactive task. For example, when looking at the positive foundations of 'good enough care', Silver includes a brick wall activity. This activity is well explained and supported with a doodle and a photograph of a completed brick wall. Through the book, there are activities and reflection points, which reinforce the learning and gave me ideas for teaching.

Silver includes many case examples, drawing on her experience, which bring to life many of the ideas such as storytelling and playing with Russian dolls. She explains their purpose, the meaning behind the task and how to use the techniques with clients. The activity called 'Empathy guesses', which follows a great chapter on parenting with PACE, really connected with me. It capsulates the importance of empathy but also the timing of our interventions. Silver also highlights when such an intervention might not be helpful and links to the theory of dysregulation.

When I started to read this book, I thought, 'OK this is a nice recap', and I was happy with the easy read. By the end, I was confident that I will be revisiting this book and using the activities. I would recommend this book to parents/carers or anyone working with looked-after children.

Niomi Wilkinson BACP (Accred), counsellor and senior lecturer in counselling and psychotherapy

Forthcoming editorial deadlines for *BACP Children, Young People & Families* journal:

9 December
for the March issue
10 March
for the June issue
2 June
for the September issue

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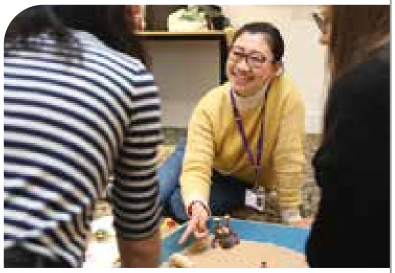

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