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WELCOME

Miles Franklin, a leading Australian author at the start of the 20th century, famously said: 'Someone to tell it to is one of the fundamental needs of human beings.'[1] Otherwise, we feel incomplete, isolated and at risk. On a daily basis, this need is often fulfilled unnoticed by family, and frequently, these days, it's a social media 'substitute family' – although, according to Jan Twenge, the effects of a life spent chiefly relating (in both senses of the word) to smartphones has led today's teens to feel lonely and anxious in unprecedented numbers.[2] In the therapy world, however, it's likely to be us receiving the most difficult stories.

For this task, especially with children and young people, we need the skill to make a relationship immediately, or the story will never emerge. We need, too, to listen to the roles played by other characters in the narrative: family, friends, teachers. Maybe inviting them into the room where appropriate. Even if they don't physically enter, they're surely there, having passed down to their children the expected family standards, some variation of self-esteem, a couple of genetic propensities, well-meant but perhaps mis-aimed advice, and/or some subtle 'scratchings on the wall'.

At times, our own fundamental need as therapists is also to tell it as it is. This can be fulfilled when we discuss a case with a co-worker. But who has the luxury of a co-worker these days? I suppose all of us can – with permission and regard to boundaries – liaise with other professionals to discuss at least some of what we hear, perceive and feel while working with the client. If not, we can feel alone, as if lack of progress is our fault, as if the chaos is our incompetence, as if the issue is beyond resolving. We definitely need to get clarity in the progress of the work/client narrative – even if it shows up as being willing to 'not know' – so that we work ethically and responsibly. If we don't have a co-worker at the workface, however, our supervisor is invaluable and always available: another credible view, but not so first-hand.

And what about self-disclosure in the therapeutic relationship? We examine this here, too, because gone are the days of deflecting everything with a young client. But between saying nothing (can we ever 'say' nothing?) and spilling all, there lurks a yawning gap – one that we often have to situate ourselves within from our ethical stance, experiential wisdom and on-the-hoof intuitions. And if the client's self-disclosure mentions a relationship with a sugar daddy… Is *anything* ever simple in our world?

And so – interpersonal stuff. Relationship. How to build it, how to relate to schools, how to work with family, or just listening out for family themes and histories. I'm delighted that interpersonal psychotherapy (IPT) is being rolled out within the CYP brand of IAPT, because so many of young people's issues involve all their relationships, and the strands of the adolescent version (IPT-A) address these issues so well. Reconnecting depressed adolescents with life and relationship, at a crucial stage in their brain development, is imperative – any suicide is one too many. Roslyn Law, who has been involved in this model for years, brings us up to date with what is happening with IPT-A – and maybe some of us who read this will go on to train in its use.

With dragons up front, and some practical map making thrown into the mix, not to mention our opinion columns, I hope you have enough reading matter for the seasonal break – if you're lucky enough to get one. But to end where I started, Miles Franklin was also a feminist who, as an author, left a legacy from her estate to provide for two literary awards, one of which is for a novel showing Australian life in any of its phases. Excellent – but I hope our legacy in therapy country will be one of showing how life can be *seriously improved* by the offer of 'someone to tell it to'. As our new branding says: counselling changes lives.

Eleanor Patrick
Editor

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1 Franklin SMSM. Childhood at Brindabella. My first ten years. Sydney: Angus and Robertson; 1963.
2 Twenge JM. iGen. New York: Atria Books; 2017.

Updated memorandum of understanding
BACP has released an updated memorandum of understanding (MoU2) against conversion therapy, to include gender identity as well as sexual orientation (including asexuality).

Please see the full statement at https://www.bacp.co.uk/media/?newsId=4136&start=3&catId=1&year=2017

DRAGON AS CATALYST

Dennis McCarthy *illustrates how the dragon is an image of unbridled life force in play therapy – and one that appears most frequently in his clients' play*

The most frequent use of dragons by children in the play therapy process is as a catalyst for change. This is a basic aspect of dragon power and the underpinning of its functioning in all the various roles dragons play. The simplest manifestation of this is as a figure that forces two opposing armies or sides to unite. An embattled child may depict two armies at loggerheads in the world they have made in the sand, stuck in a seemingly unresolvable state of stasis. Then out of the sky swoops a fire-breathing dragon and the armies immediately unite, their initial quarrel forgotten. Or a dragon emerges up out of the depths of the earth and the same immediate unifying response is triggered. Often it may be three armies or many more, and there may be great chaos in their battling, and it is unclear who is on whose side. Then a dragon enters and the chaos organises; the myriad forces unite. This simple act of joining forces can, at the right time in the child's process, reflect and facilitate a shift in their inner and outer conflict.

An oppositional child may become more able to be a part of his or her family system or peer group. A child whose own neurophysiology has rendered them in a state of defensive opposition may soften as the two sides align. The process of change may have been fostered in weeks of preparatory play. This play probably involved the same child battling me in various ways or using materials that express and discharge negative aggression safely. I am sure that I initially joined them in their dysregulated play, mirroring them with the unspoken goal of fostering a sense of regulation. They may have fought me unfairly to secure victory and I may have both allowed and challenged this. But at last the child's defence system is ready to find a new, more functional form. The dragon makes this happen, arising in this case out of the very dysregulated aggression that was part of the problem. Its destructive power makes it a potentially creative presence. And there are other impasses that the dragon as catalyst helps to resolve.

Seven-year-old Michael had been attacked by two large dogs and come for treatment to address what was becoming an escalating phobia. He wasn't badly hurt by the dogs but was very shaken emotionally. He had become phobic, not only of dogs but also of going outside, in case he might see one, or they might see him. He was contracting into himself.

The problem with genius

In meeting with his parents, initially I asked them what might have concerned them about their son prior to the dog attack. I usually do this when a child has experienced situational trauma, such as a dog attack, to have a sense of who they were prior to it. Knowing what their prior strengths and weaknesses were can help us know how to help them, seeing each child as more than traumatic experience. In this child's case, his parents said they had concerns about him even when he was quite young. He was a maths genius, doing mathematics on a high-school level at age four and scoring in the top 10 on a national test at age five. His school was thrilled to have such genius in their midst, but his parents saw the downside of this. His obsession with numerical formulas was at times all consuming. They were not concerned that he was autistic, as he had many friends, was very relational, and quite empathic. But they felt there was a concomitant rigidity in him because of the discrepancy between his mental and physical development. They were very eager to have him come and play.

Michael was really quite wonderful and engaged easily in play. But his numerical obsession tinged everything. His initial drawings of himself as a monster were all numerical formulas, although they did have teeth. His initial sand worlds involved dogs being run through labyrinths made up of numerical formulas, especially the formula for Pi. These were drawn in the sand using small gems. The formula's task was always to 'boggle the mind' of the dogs. I asked him if all these mathematical formulas boggled his mind too and he admitted that they did. 'But it's better than the black holes I was obsessed with when I was three,' he said. In his second version of the same world above, he added two statues of the god Shiva standing and watching what was happening. He and I and the gods watched while dogs were chased by numerical formulas. His imitation of the dogs' barking was very convincing.

Getting in touch with the physical self

For a few sessions, he explored a variety of play experiences in which his movement repertoire increased. He found that pounding on a mattress in my office was greatly enhanced if he ran from across the room and then leapt up into the air. He lay down on the same mattress and threw pretend tantrums, eliciting much laughter as well as a freer sense of moving. He enjoyed building and then knocking down tall block towers, often erupting into loud barking as he did so. All of the above was done in the spirit of play and all helped him get out of his head, or at least begin to integrate his physical self with his intellect.

Then I challenged him to a round of 'The Cheating Game', which is a drawing game that I created, useful with both rigid children and timid children. In it, each person draws monsters on different sides of the same piece of paper, separated by a river perhaps. There are three rules to the battle that ensues: you can only draw three monsters, you can only destroy part of one of your opponent's monsters in any turn, and third you have to cheat, ie break the first two rules. This child was thrilled with the game. And, not surprisingly

Meanwhile I drew a large dragon on my side that only ate mathematical formulas. I assured him that it could gobble up all of those numbers with one bite

His parents felt that his intellect, so overly developed at such a young age, had been a hindrance to feeling truly connected to others

perhaps, all of his monsters were mathematical formulas! They were not even vaguely disguised as monsters. Numbers and parentheses and multiplication signs were amassed on his side of the paper and it was apparent that they gave this child joy even as they encumbered him.

Meanwhile I drew a large dragon on my side that only ate mathematical formulas. I assured him that it could gobble up all of those numbers with one bite. He saw with alarm how I had tricked him into varying his obsession. He would now have to make some figures that were not numbers. But he was also charmed by this trickery. In order to not be destroyed, he had to make other monsters, which he readily did. I think he was relieved to be free of the obsession, at least for the moment. He drew a large dragon that successfully battled mine. After this, dragons showed up in his sand worlds as the dog provokers, instead of numbers, and the architecture of the scenes became much more complex as a result.

From the onset, Michael left my sessions very stirred up emotionally, despite seeming very happy in his play. He would often weep on the ride home, or speak baby talk. His parents saw this in a positive light as a sign of loosening. They felt his weeping was both grief and relief over the loss of his numerical obsession. They also felt that his intellect, so overly developed at such a young age, had been a hindrance to feeling truly connected to others. The dog phobia rapidly dissolved.

One of his last sand worlds depicted a number of dogs in a very complex series of tunnels that he referred to as a labyrinth. There were no numbers in this world. The dogs were playing and taking baths and resting. Surrounding this world, on the rim of the sandbox, were numerous dragons that were keeping an eye on the dogs, but otherwise not interfering. They seemed like guardians. Seen from above, the structure of the sand looked like a spinal column or neural dendrites. For me, it seemed like his entire organism had been positively influenced by the play therapy relationship.

In his last visit, Michael made one final play scene, in which numbers were dressed up as monsters so they couldn't be recognised as numbers. This seemed to be a brilliant compromise on his part. He had maintained his sense of integrity while also allowing for subtlety, protection, and the possibility of broadening his frame of reference further – my support and gentle provocation helping him along the way.

This is an extract from **Dennis McCarthy**'s chapter, 'Harnessing the Dragon', in *Rhythms of Relating in Children's Therapies*, edited by Stuart Daniel and Colwyn Trevarthen (Jessica Kingsley, 2017) and reprinted with permission of the publisher.

No man (or young client) an island

Continuing her short series from the shop floor of her varied practitioner and training experience, ***Alix Hearn*** *brings us some reflections on co-working in child and adolescent psychotherapy*

When Winnicott stated that 'there is no such thing as a baby, he was, of course, referring to how a child comes into being *through* and *in* relationship – how the baby relates to the object (the mother).[1] Latterly, Stern[2] and Trevarthen[3] expanded Winnicott's idea in the form of intersubjectivity: how the young infant is a co-creator in the mother-child dyad. In most forms and approaches of psychotherapy, we return to this crucial component – the client-therapist relationship. We have been wounded in relationship and through relationship we heal. There is a rather strange irony, therefore, in the isolation of the therapist who works in private practice – we (generally) sit alone in rooms, with little social and professional contact, other than with our clients. But how often do we see each other work? How might our colleagues perceive this client? What interventions might they make? Would they see something very different?

It's really not enough to work in isolation with the child. We have to be in the system with the child, working within it. Maybe advocating for the child at times. Maybe helping to translate the meaning behind their behaviour, or facilitating reflective capacity in the child's environment. Sometimes, working with just the child or young person does work and can be effective, depending on the issue, but other clients can remain untethered, unclaimed, if we replicate their sense of dislocation and loneliness by not working with the systems around them.

With 'mind-lessness' sometimes being the norm, working alongside another therapist with the same family provides another 'mind'. It is our hope to model how minds can think together, how the 'parental couple' (us) can bear distress yet still remain thinking, wondering yet solid. This can be particularly potent when one or both therapists feel 'stuck' or paralysed in some way. When we reflect on our separate but joined experiences of the family, we can see similar patterns emerge, bridges between how I might experience the child, or the family system, and how my colleague experiences the parent and the family. If I were working alone with a child or family, my countertransference would be mine alone and I would need to make sense of it. However, with another 'mind', a singular experience of countertransference becomes a shared experience, a form of 'binocular vision'[4] whereby a family's way of relating is made visible. By sifting through our experiences together, and our similar bodily sensations or recurring themes in the separate work with the child and the parent, we can begin to really 'get hold' of a family who otherwise might prove elusive.

There have been many occasions when this has been the case for me while working in private practice alongside other therapists and child psychiatrists. If a family presents as somehow difficult to understand, both on a practical and psychological level, working closely and collaboratively with a colleague (who can work with the parents while I work one to one with the child) stimulates our capacity for reflective thinking and our ability to mentalise and make sense of the family dynamics. This has been particularly useful when a colleague is offering both an alternative perspective on the family *as well as* a shared language – for example, when I have co-worked with a psychodynamically trained child psychiatrist. With some clients, there is also comfort to be had from dialogue and reflective thinking with my co-worker – that it is not 'just us': there is a wider system to consider. A case really may be as complex as we think it to be.

Some families need as many 'minds' thinking about them as possible. I have often worked alongside an experienced psychodynamic psychotherapist and an educational psychologist to provide a holistic framework that involved parent work, child work and reflective thinking with the school. If the young person is not able to engage within a 'traditional' therapeutic setting, we have to think flexibly together and offer a completely tailored approach for the family, drawing upon our own strengths as practitioners and weaving together the differing threads. Being able to think together with my colleagues becomes an invaluable part of these processes and a hugely necessary part of bearing a family's distress. My aim is to provide containment for the family, and to provide a mental

space that can 'think'. Discussion with my colleagues provides a co-created container and rich exploration of the case from differing perspectives, which allows us to really think and reflect on the family dynamics and how best we can meet the needs of the family. This has been a particularly potent mode of working when the family has been unable to access established therapeutic routes.

But what if a family's way of relating is more binary than binocular? Splitting is a concept that we may throw around, but if allowed to breed, it can be a destructive force when working as part of a multidisciplinary team or co-working with another therapist. Being the 'bad mummy' alongside the 'good mummy' colleague can be challenging for even the more experienced therapist, especially if the therapists are working independently and not within an overall holding framework. How do we ensure that we do not identify with these allocated roles and play them out in the work? I would argue that when we work with child and family dynamics we are in the realm of primitive non-verbal feelings, sibling rivalry, maternal ambivalence, our own 'child', and our own internalised parents, no matter how 'processed' our material is. How easy it might be to buy into the idealising transference – particularly with a seductive client – to believe our own 'good press'. How easy it might be to become the critical parent and allow 'attacks on linking' within the co-therapist dyad to occur. Joint or peer supervision plays an integral part here – we need the 'super-vision' of the 'other' to remind us of our vulnerabilities and to hold our co-minds together. Christopher Bollas' thinking can be helpful here – that when in groups, we each hold something for the other members.[5] When co-working with other therapists, which parts are we then holding for the other therapist(s)? How essential it is that we enter into relationship with those parts to avoid splitting and acting out.

Ultimately, our endeavour is to use these insights and learning *in the work*, to inform what we name to the client, or when we need to gauge the temperature and bear it for them. By holding the different parts of the family's narrative together, and the parent-child relationship, the aim is that, as co-therapists, we embody Winnicott's environmental mother,[1] enabling the 'indwelling' of the family body to take root in the therapeutic relationship.

Some clients can remain untethered, unclaimed, if we replicate their sense of dislocation and loneliness by not working with the systems around them

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5 From my notes taken during a talk by Christopher Bollas on 'The democratic state of mind' at the Freud Museum, London on 2 October 2017.

Setting up a whole-school counselling service

Katia Houghton *reflects on the layers of complexity involved in the enterprise*

I'm waiting in reception. Head teacher Carrie is on her way to meet me, the new school counsellor. A head teacher at another school has told her that having a counselling service has made a huge difference to him, and Carrie really wanted to try this for herself. I've met with Carrie only once and wondered what to make of her. She seemed keen to appoint me, but also a bit unsure about how I might help the school.

She stretches out her hand.

'Welcome, Katia. We've got a list of people we'd like you to see. This is your room – it's a bit small, I'm afraid, and we're still trying to sort out a desk, but I'm sure you can make yourself comfortable. Your first client, Molly Parks, is a very quiet girl – she won't talk to anyone, but now you're here, I expect you can sort her out. We're so lucky to have you!' Minutes later Carrie disappears behind the door marked 'Head teacher'.

Suddenly I feel very alone.

'The first task of any therapy is to create a working alliance, in which the patient feels committed to the therapy and has confidence that the therapist can help.'[1] When Molly arrives for her session – *if* she arrives for her session – it will be up to me to try to begin to forge an alliance strong enough to start to nurture the possibility of trust. But I know there are other equally crucial relationships at stake, and among the most important of these is my alliance with Carrie.

A whole-school service

The school, in loco parentis, like Winnicott's good-enough mother, needs to provide a 'facilitating environment' for its pupils to grow, establish independence, and thrive.[2] This is part of Carrie's job – and one of the most important aspects of my role as whole-school counsellor is to support her in that. But the ethos of whole-school counselling goes further. The Department for Education's blueprint about counselling in schools[3] quotes BACP: 'School-based counselling is likely to be most effective where it is delivered as part of a whole-school commitment to improving mental health and wellbeing. Emotional health is everyone's business.' In other words, in a school in which that really is the case, it is recognised and understood that the task of developing emotional intelligence, of acknowledging and talking about feelings and relationships, takes place not just in the counselling room but everywhere.

'School counselling isn't private practice.'[4] In private practice, therapy is primarily about the relationship between two people. In the course of that relationship many significant others may join them in the room – parents, grandparents, siblings, colleagues, friends – but in an institution there are extra layers of complexity. 'The individual in life is equally determined by the various groups of which he is a part, some more, some less fundamental: his culture, his nation, his family, his clan, his time.'[5]

When I first started working in a school, this raised some interesting dilemmas for me. Steeped in a classical psychodynamic training, with its deep commitment to maintaining boundaries and neutrality for the transference to develop, I quickly understood this just wasn't going to work. Firstly, young people will feel uncomfortable if you come across to them as detached. Secondly, in a school, the entire institution tends to crowd into the room with us – *sometimes literally* when the session is interrupted by a member of staff looking for keys or students banging on the window, but *always metaphorically*. And what our clients bring to us *in* school is also in some way unconsciously about school. Of course, many aspects

In selecting Molly as my first client, the institution is issuing a challenge: 'Put that in your pipe and smoke it, talking cure! See what you can do with this!'

of what goes on in the counselling room remain profoundly private – that *isn't* everyone's business – but it is a business that at some level involves *everyone*.

Anthropologist and systems theorist Gregory Bateson suggests that when we effect a change to one part of the system, it will have repercussions for every other of its aspects too. 'The contexts of human relationship in particular require that we do not chop up interactions which comprise whole systems.'[6] It follows then that to insist that counselling is an isolated activity, separate from what goes on in the school as a whole, is to maintain an illusion.

But it is a powerful illusion. Bion talks of *valency* – 'the individual's readiness to enter into combination with the group in making and acting on the basic assumptions'.[7] If, for example, there is frustration and rage in the staffroom, but this remains unexpressed, the anger may be enacted in student vandalism or fights in the playground. For those involved, this won't feel at all systemic – it will feel personal. Different individuals express their capacity for valency in different ways. Certain young people kick off at times of tension; others may express the uncertainty of the institution in anxiety attacks, or articulate its unacknowledged hate by turning it against themselves in self-harm. It works the other way too: when the institution as a whole is able better to articulate and think about what is really going on, this is reflected in the emotional awareness of the individuals who comprise it, and there may be less acting out. This unconscious curriculum is what the whole-school counsellor tries to take into account.

The school's challenge to me: Molly

That said, when Molly arrives for our first session, I am not thinking about systems – just about her. She is a withdrawn 13 year old, who speaks in monosyllables and looks mostly at the skirting board. I learn that Molly has been feeling very low for at least a year. Her parents divorced just before she started Year 7, but she had seemed to settle into school quite well. Her father lived close by at first, but last year moved to Canada with his new partner and her six-year-old child. Internally, I wonder about the pain of feeling discarded by her father and then replaced. She and he speak via Skype, but time differences are a problem. Molly says she doesn't speak in class because she just isn't interested. She can't see what all the fuss is about. She doesn't like this school, but then who does? When she does have contact with her dad they don't have much to talk about. All her subjects are boring, but she can't imagine what she'd rather do – weekends are basically boring too. Later, stopped in the staffroom by the form tutor who made the referral, I learn how frustrated and useless Molly's teachers feel. Apparently, she barely engages with anyone, and sits by herself at break and lunch, untouchable in her misery.

Molly's mother has also been in contact. On the surface, we have a practical conversation about how Molly could be best helped at home and whether she is coping with her schoolwork (she scrapes through), but I try to respond to the unconscious questions as well: Do you think I'm a bad parent? Is it my fault? How can you help, when I can't?

I know that, in one sense, Molly is a test. In selecting Molly as my first client, the institution is issuing a challenge: 'Put that in your pipe and smoke it, talking cure! See what you can do with this!' There may be envy in that: who is this upstart counsellor who thinks she can fix our school, when we've been working here for longer, with dozens of students at a time, and rarely have the luxury of a confidential one to one? But there is also hope: perhaps this counsellor really could help change some of the difficulties that make us feel useless and incompetent. Treading this line between envy and hope is excruciating for the head teacher and staff, and it's one reason why the process of setting up a whole-school counselling service can feel so precarious.

I am conscious that the school community was addressing a serious need when it made provision for a counsellor, but that, at the same time, more than anything, it wishes that this need did not exist and that it could manage everything by itself. It's not unlike Molly's dilemma – let down by her parents and abandoned by her dad, disengagement is one way to negate these blows and show that she doesn't need anyone: she can manage by herself. This is what I think her silence is telling me in our sessions. They're hard work. I feel useless, overwhelmed by my ineptitude, and constantly braced for the therapy to break down. But Molly continues to come.

The practical stuff

Alongside working with Molly and my other clients, there is the practical business of getting a counselling service up and running. The question of how to go about this loomed large before I began my job, and it is certainly time consuming, but not necessarily in the way I had expected it to be. I had thought it would simply be a case of transferring to my new school the system I had become familiar with at my old one. The Welsh Assembly/BACP *School-Based Counselling Operating Toolkit*[8] gives lots of guidance, including sample generic paperwork, to help with this. But one size doesn't fit all. The system I knew just doesn't translate, and we need to organise referrals and appointments differently. We soon have a waiting list, and have to figure out a way of bearing that. I was determined to resist an emergency model in which those who demonstrate the most distress and cause the community the most anxiety are counselled first. It doesn't always work. Sometimes I get caught up in the sense of urgency and break my own rules. Once or twice that is the right decision; at other times, with the benefit of hindsight, perhaps not.

As the first term progresses, I begin really to understand that much of my work takes place outside the counselling room – at the kettle, in the staffroom, in a 30-second conversation in the corridor. A school inspection is looming, and staff are feeling the pressure. Some are experiencing the senior leadership team (SLT) as out of touch: 'They always say my lesson plan is excellent and the formal observation is great…*but* – and then they pile more work on me. What more do they expect?' There is an atmosphere of hopelessness and frustration; some teachers express this as short-temperedness or lack of co-operation with one another; in others, it bursts out in impatience when yet another student has to miss a class to go for counselling.

According to Bateson: 'To say that someone is argumentative, dominant, a leader, a communicator, and so forth is to distort a description of relationship by proposing that some thing or property is located within the boundaries of one of the relata.'[6] I think about this institutional split between the SLT and the rest of the staff, between the manic effort everyone is making and the accompanying anxiety that we're all just running on the spot in a paradox of paralysis and hopelessness. Paralysis and hopelessness are also characteristic of Molly, but her response is inactivity. Still reeling from the split in her family, a family that does not talk, she is too afraid to commit to anything other than protecting herself in a cocoon of detachment – a place that is safe but desperately lonely and unsatisfying.

In some ways, as the resident school counsellor, I am in a far better position to see this than a peripatetic counsellor from an outside agency, but *any* counsellor, not just *the* school counsellor, can think in whole-school terms. And in one way, the agency counsellor may have a small advantage over me. I, too, am one of Bateson's relata. My own valency means that I am just as likely as anyone else in the school to get caught up in institutional dynamics. The night before the Ofsted inspection, I find myself staying up late, checking my knowledge of safeguarding acronyms and memorising the function of different fire extinguishers. This is when the external space of supervision, with a supervisor who really understands what it's like to work in a school, becomes so valuable. And, over time, this is how the process of making emotional health a matter for everyone becomes reflexive. It's my job to support Carrie (the head), and sometimes – for instance, when the head of maths wants to introduce time-limited counselling for GCSE students to prevent them from missing too much work, and Carrie holds firm – it's her job to support me. We are beginning to form a pastoral team.

At Easter, I am invited to contribute to an inset day, and suggest some exercises designed to help staff talk to pupils about anxiety. I hope the experiential process will encourage them to talk to each other too. I continue to meet with Carrie regularly. Sometimes she has to cancel at the last minute, sometimes the meetings are short and perfunctory, but I keep going. Molly also continues to attend her sessions. One day, just before the summer half term, she tells me that she has started playing the guitar again and has written a song. 'I've got it on my phone. You can hear it if you like,' she smiles, getting out her mobile. Carrie stops me in the corridor as Molly leaves. 'She seems to be doing better,' she says. 'It must be the new music teacher. They really get on.'

Having worked for several years as part of a school counselling team, **Katia Houghton** now runs the counselling services in two schools, where she works with clients aged four to 18. She also has a private practice in which she sees adults as well as young people, and is currently undertaking a further psychoanalytic training at the Site for Contemporary Psychoanalysis in London.

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Interpersonal psychotherapy for adolescents

__Roslyn Law__ has been involved in IAPT and the children and young people's IAPT (CYP IAPT) for many years. Here, she brings us up to date on interpersonal psychotherapy for adolescents with depression (IPT-A) – an evidence-based intervention that has been gradually integrated within the IAPT collaboratives, and which has developed organically as a result of ongoing research to include the more recent addition of skills-based groups for teens and family-based interventions with pre-teens

Background

CYP IAPT is a service transformation programme, delivered by NHS England in partnership with Health Education England (HEE), that aims to change the way mental health services for children and young people are designed and delivered across England. The programme began in 2011 and aims to achieve 100 per cent geographical coverage across England by 2018. CYP IAPT covers children's services provided by the NHS, the local authority, the voluntary sector and the youth justice system. The aim is not to create new CYP IAPT services but rather to embed core principles within existing services through collaboration and training. Central to CYP IAPT is heightening public and political awareness of the mental health problems experienced by children and young people, and ensuring that the services they receive are accessible and easy to navigate, deliver effective and evidence-based treatments, use regular feedback and outcome monitoring to ensure accountability, and are shaped by young people's views through shared decision making. These principles are central to the Government's vision of children and young people's mental health services by 2020, set out in *Future in Mind*.[1]

Implementation of the CYP IAPT principles is organised around five learning collaboratives across England. Each learning collaborative is made up of clinical services, commissioners and higher education providers working in regional groups. Training is provided for practitioners, supervisors and service managers to ensure the CYP IAPT principles are woven into the fabric of participating services. The packages of training in evidence-based therapies delivered by the five learning collaboratives vary in scope, although the content of each course reflects nationally agreed curricula, which are augmented iteratively, based on evolving evidence and feedback from participants.

IPT-A

IPT-A has been recommended as a first-line treatment for depression in adolescents by the National Institute for Health and Care Excellence (NICE) since 2005, and training in IPT-A has been provided by the London and South East collaborative since 2015. It was added to the North West collaborative's programme in 2017 and has previously been delivered in Reading and Northumbria. IPT-A achieves a very natural fit with the CYP IAPT principles, as it is evidence based, uses measures as monitoring and feedback tools in every session, and is highly collaborative in style. Over 100 therapists have completed training in IPT-A since 2015, bringing this form of treatment to more than 450 young people with depression across 50 partnerships around the country. The therapists who have attended the training come from a wide variety of core trainings, including clinical psychology, child psychotherapy, social work, counselling and mental health nursing.

IPT-A is a new therapy to most children and mental health services, and the breadth of training provided by CYP IAPT courses reflects the evolving understanding of the valuable contribution this approach can make to work with adolescents with mood and interpersonal difficulties. I have been fortunate in being at the heart of this development – writing the curricula for practitioner and supervisor training, and delivering or collaborating with trainers in all the training providers. It is especially exciting, as each year goes on, to welcome increasing numbers of CYP IAPT graduates in delivering training and supervision to their colleagues, ensuring the day-to-day realities of integrating a new evidence-based therapy into a service is held in mind in a realistic way.

IPT-A is a modified version of interpersonal psychotherapy (IPT), an empirically supported treatment originally designed for use with adults with depression.[2] Laura Mufson, a New York-based clinical psychologist, took the core principles of IPT and adjusted the structure and emphasis to better suit the developmental needs of adolescents as they enter an exciting and tumultuous period of interpersonal development.[3] Mufson recognised the symptomatic similarities between adolescent and adult depression, the predictive nature of early onset depression for later mental health difficulties, 75 per cent of which will have begun by their mid-20s, and the high prevalence of social and interpersonal difficulties for many adolescents, who frequently have less control over many aspects of their interpersonal world than adults – for example, in reconstituted families and care placements. The therapy was modified to reflect the many developmental changes adolescents go through emotionally, cognitively and socially, and in their increasingly peer-focused attachments, as their independent identities evolve. However, the model also explicitly promotes family involvement during this transitional period, with at least three sessions offered to parents or carers, in addition to the 12 individual sessions with the young person. This overlap with systemic interventions at the heart of IPT-A informed subsequent modifications, in which parents participate in 50–100 per cent of sessions with pre-adolescents[4] and young people for whom conflict with parents is a central issue.[5]

In 2016, I also wrote a self-help manual for IPT-A, *Defeating Teenage Depression: getting there together*,[6] which addresses the young people who use it and their parents directly. This extends the model to include additional reference to adolescent brain development and the role of mentalisation in understanding and treating depression in an interpersonal context. This is now widely used as an in-session workbook in CYP IAPT training and by IPT-A practitioners and supervisors. These additions – along with training in family-based IPT (FB-IPT) for

Social withdrawal at the adolescent stage of development is especially problematic. Put simply, this is a period to use it or lose it

pre-teens with depression[4] and IPT-A skills training (IPT-AST) groups[7], which aim to prevent depression in adolescents at elevated risk – have been added to the IPT-A CYP IAPT curriculum, showing the dynamic nature of training and continual efforts to reflect the best current evidence.

A life-event therapy

IPT-A is often described as a life-event therapy, combining medical and social models of depression and formulating each episode of depression in an interpersonal context. It is organised around four focal areas that capture common life events known to create vulnerability to depression:

- interpersonal role transition, eg family separation or rejection by a friendship group
- interpersonal disputes, eg with a parent or friend
- interpersonal sensitivities, eg difficulty making or maintaining relationships
- grief following bereavement, eg losing a parent, sibling or friend.

One theme is chosen to help formulate manageable targets for change amid often very complex interpersonal circumstances, and this focus remains at the heart of post-formulation work. The focal area directs the emphasis of subsequent work on communication skills, interpersonal engagement, problem resolution and symptom reduction. For example, role-transitions work will focus on clarifying and mourning the loss inherent in a change of role, and developing the skills and interpersonal support necessary to function effectively in a new role; while work on interpersonal disputes will focus on clarifying non-reciprocal expectations around central issues in a relationship, and developing more effective communication strategies to negotiate mutually acceptable alternatives that will allow the relationship to move beyond recurrent patterns of conflict. In CYP IAPT training casework, work on transitions and sensitivities has alternated year by year as the most commonly chosen focal area – highlighting the relevance of working with change and difficulties in negotiating new aspects of peer relationships for many adolescents.

The integration of mentalisation-based ideas and techniques has helped to operationalise the way IPT-A seeks to re-establish the currency of social learning, the value of which is obscured in depression. Biological development interacts with social development during adolescence to equip young people to engage with the increasingly complex social world that is emerging around them. The physical machinery of an adolescent's brain is shaped for life by the interactions they experience. However, the cost of an emerging capacity for more complex reasoning, perspective taking and forward planning – all of which are under various stages of construction during adolescence – is a vulnerability to depression when tentative goals and interpersonal experiments are frustrated or unsuccessful. This can lead to prolonged periods of withdrawal if an adolescent becomes weighed down by the hopelessness they feel about engaging in an increasingly unpredictable and demanding social world. Social withdrawal at this stage of development is therefore especially problematic. Put simply, this is a period to use it or lose it. By scaffolding this social learning and limiting isolation, IPT-A positions itself to be highly attuned to central tasks of adolescence.

IPT-A progresses through three phases: assessment, formulation and goals-based work, and finally preparation for ending. Assessment is

completed during the first four sessions, organising the young person's experience of depression in an interpersonal timeline and populating the story with an interpersonal inventory. This leads to an interpersonal formulation, which highlights the relevance of one of the four focal areas and the nature of the work that follows. In the final phase, progress is reviewed and reinforced, attention is given to the impact of ending therapy, with one member, namely the therapist, leaving the young person's support team, and plans are constructed with the remaining team members to help the young person to maintain the gains they have achieved and to respond quickly if symptoms of depression recur in the future, as they will do for more than half of young people who first experience depression during their teenage years.

Evidence

The research evidence behind IPT-A, which supports its place in CYP IAPT as an evidence-based approach, has followed a pragmatic trajectory, addressing questions that are relevant and important for clinicians. The early open-trial studies established that the approach is acceptable to young people and achieves the change it set out to: that is, reduced symptomatic distress and improved interpersonal functioning, with changes in symptom scores between baseline and session four being most predictive of good outcomes. When the intervention was delivered by experts, 80 per cent of young people achieved recovery and this was largely maintained over the following year.[3] Subsequent studies demonstrated significantly better recovery rates with IPT-A than those achieved with clinical monitoring or school counselling, and equivalent outcomes when compared to CBT. Although targeted at depression, published evidence and CYP IAPT outcomes have also demonstrated a positive impact on comorbid anxiety – and therapists completing training casework have frequently reported reduction or cessation of deliberate self-harm.

The CYP IAPT programme is committed to delivering high-quality skills training and supervision that is informed by the best available evidence at every stage, including awareness of when practice is pushed beyond the limits of the current evidence base. A funding proposal has therefore been submitted to support a multi-trial to evaluate practice and outcomes in IPT-A and CBT following CYP IAPT training, to provide much-needed evidence from services in England, and to be able to broadly comment on how this approach fits in a UK NHS setting, albeit there are differences between the countries. The CYP IAPT programme has also worked in close collaboration with leading IPT-A researchers, who have developed the core IPT-A model to cover family-based and preventative interventions. CYP IAPT trainees, practitioners and supervisors attended training with these researchers in 2016 as part of the expanding curriculum programme.

Further training

The IPT-AST and FB-IPT models were included in the core training because they more fully develop trainees' work in central aspects of IPT-A. The IPT-AST eight-session group model provides excellent guidance on how to engage young people in experimenting with new forms of communication and interpersonal problem solving. Peer-supported learning is promoted through psychoeducation, role play and group problem solving – building confidence and understanding before group members try to use their new skills in their own life settings. Key ideas are captured in 'teen tips', which have been developed in CYP IAPT into flexible tools that are used in session and that young people can carry with them between sessions as reminders of positive communication strategies.

FB-IPT also makes use of these tips and extends their use to provide similar practical suggestions to parents, who attend every session with preteens with depression – for example, put your own oxygen mask on first. This approach not only attends to the young person's distress but also addresses issues around parental mental health and how to manage core parenting challenges. This attention to parental mental health mirrors IPT-MOMS,[8] which has successfully used IPT with mothers of young people attending mental health services to reduce symptomatic distress in the mothers and, after a time delay, their children. In FB-IPT, the young person and parent work separately and together over 14 sessions to formulate the main interpersonal challenges faced by the family and to practise using new strategies each week, with the FB-IPT therapist guiding and supporting role plays and

The CYP IAPT programme is committed to delivering high-quality skills training and supervision that is informed by the best available evidence at every stage, including awareness of when practice is pushed beyond the limits of the current evidence base

shared decision making between the parent and child. Introducing CYP IAPT training in this approach in 2017 expands IPT-A-informed assistance to a younger population and equips IPT-A therapists to work more sensitively and effectively with the parents, who attend therapy less frequently with their adolescent children. The IPT-A therapists who attended both additional trainings were universally enthusiastic about the positive and constructive contribution these developments in the model have made to their routine and evolving practice.

Supervision

In addition to practitioner training, a national programme of IPT-A supervisor training has also been developed to support provision of IPT-A across the country. The small number of IPT-A therapists meant that this aspect of training initially relied heavily on input from IPT supervisors more experienced in working with adult populations, who had completed specifically designed training to highlight developmental and contextual differences when working with young people and families. While this was of invaluable assistance in the first years of IPT-A training in CYP IAPT, increasing attention is now turning to equipping the CYP IAPT partnerships' workforce to provide training for each other. Twenty therapists have completed supervisor training since 2015 and are working within services and in training centres to help new trainees to deliver IPT-A, FB-IPT and IPT-AST. This training has also been greatly enhanced by contributions from young advisors and participation champions, who co-design teaching materials and deliver workshops for practitioners and supervisors.[9] A national programme is now being co-ordinated through the Anna Freud National Centre for Children and Families to establish regional hubs of excellence in IPT-A, which will hold local responsibility for promoting and supporting the provision of this therapy across nationwide networks of practitioners and supervisors.

Roslyn Law is a clinical psychologist and has used and taught IPT and IPT-A since 1997. She was national lead for IPT in IAPT and is currently IPT and IPT-A lead at the Anna Freud National Centre for Children and Families and Deputy Director of CYP IAPT in the London and South East Collaborative. Her book, *Defeating Teenage Depression: getting there together*, was shortlisted for the BMA Popular Psychology book award in 2017.

Further information

For further information about IPT-A training for CYP IAPT, see

- https://cypiapt.com/postgraduate-cyp-iapt-training/
- www.annafreud.org/training/training-and-conferences-overview/

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Training – an ethical onus

Rigorous, specific training for counselling children and young people repays itself many times over – and fulfils our ethical responsibility to our under-18 clients. ***Lisa Nel*** *outlines what is needed from such training, and its advantages*

All counselling with children* will soon require some form of prior, focused training. Students on BACP-accredited courses aimed at adult counselling currently have to be taught and assessed in the Basic YP Competences[1] before undertaking a child placement. In May 2019, these Basic YP Competences will be replaced by Stage 1 of the *Counselling Young People (11–18 Years) Training Curriculum*, which is now available on the BACP website.[2] Both the *Basic YP Competences* and the elements within Stage 1 of the YP curriculum, reflect a consistent minimum standard for beginning practice with CYP. All counsellors working with children and young people are expected to receive robust and appropriate supervision from supervisors who are themselves competent to work with CYP.

UKCP has taken the further step of requiring any member who works or wishes to work with under-18s to provide training evidence for their Child and Young Person Proficiency Marker: 'The Child and Young Person Proficiency Marker is the means whereby UKCP signals to the public that registered adult psychotherapists and psychotherapeutic counsellors who have this Marker have also met a minimum standard of proficiency in relation to therapeutic work with children and young people. Minimum standard is defined as a level of knowledge and skill that aims to enhance the safety of child and young person clients, and ensure that the therapy provided meets their human right of access to appropriate services.'[3]

Society's failure to both tackle the causes of harm to our children and provide adequate healing to mitigate its effects is generating a rising wave of distress that shows no sign of abating. Scant support for children's mental health arguably stems from the undervaluing of both children and the importance of nurture. It seems that in schools, charities and other settings, where it exists, counselling for children is provided largely by volunteer or low-paid counsellors with adult-orientated diplomas.

Rigorous, additional training for counsellors working with children has the potential to add both professional value for counsellors and therapeutic value for the children they support. This article explores what is needed from specialist under-18s training.

This year, my work as a school-based counsellor – in three primary schools and one secondary school in Cornwall – has been punctuated by visits to Swindon to teach the Post-Qualifying Diploma in Counselling Children and Young People. Pioneered by UKCP-registered child psychotherapist Lynn Martin, this Level 7 training has been successfully delivered to many hundreds of counsellors throughout the UK over the last 18 years. When I signed up to do the course, which I now deliver, I'd already been working as a school-based counsellor for three years. Each course weekend brought fresh echoes from that first counselling certificate of the (somewhat reluctant) recognition that maybe I wasn't as good a listener as I'd thought I was. Hard though it was to juggle studying again with the demands of family and work, I knew that taking time out to learn, read and reflect specifically about counselling children would help me do it better.

I believe there are three key, interrelated elements involved here: knowledge and understanding, specific skills, and ways to strengthen professional confidence.

Relevant knowledge and understanding

Having a solid grasp of child development and attachment styles is vital to selecting effective interventions. For instance, a six year old who still thinks in concrete terms cannot be usefully invited to imagine alternative possibilities. Noticing a withdrawn, avoidant attachment behaviour pattern in a 15 year old, enables us to focus attention away from the counsellor-client relationship enough to start building a relationship in ways that feel safer.

Understanding the basics of the brain and the biochemistry of emotions has dramatically changed the way in which we can help children (and adults) to regulate overwhelming emotion. Dan Siegel's hand model of the brain[4] provides a memorable strategy for supporting anger, at the same time as helping to

It seems that in schools, charities and other settings, where it exists, counselling for children is provided largely by volunteer or low-paid counsellors with adult-orientated diplomas

reduce shame. Whether it focuses on the window of opportunity for change offered by the increased neuroplasticity of the teenage brain,[5] or interventions for developmental trauma and PTSD by authors such as Van der Kolk[6] and Levine,[7] scientific research is bringing fresh hope and ways to heal the effects of trauma, abuse and neglect.

Clarity about **children's rights, and the laws relevant to under-18s** protects both children and ourselves. We don't have to become experts in the law, but do need to know what directly affects our practice, as well as how and where to find the answers to questions. Training needs to highlight resources such as *Therapy with Children: children's rights, confidentiality and the law*[8] and the Coram Children's Legal Centre helpline.[9] Importantly, a training course provides the opportunity to discuss ethical dilemmas, big and small, with colleagues on the course – from the tensions that can arise between confidentiality and safeguarding, understanding the law relating to FGM, or how to call for a student who hasn't arrived.

Delving into discovering what is *really* important to children of all ages can also greatly help us to engage them in counselling. But society is ever changing, which makes **staying up to date with youth culture** part of the job. From social media to gaming, this might range from a brief viewing of *Grand Theft Auto V* (an 18+ electronic game involving crime, violence, sex, drugs and alcohol) to learning what is meant by 'Mandem' (meaning 'that bunch of men or boys'). But the surest way to be 'in the know' is to be curious: asking children what matters to them and listening to what they say.

The inclusion of **some psychoeducation** in sessions is an element of the **reparative parenting** we can sometimes usefully provide, and is another departure from many adult models. For instance, we may be the only adult ever to teach a child to recognise different emotions in their bodies and to use this information in safe, healthy ways. We are often the only attuned adult available to support the constant losses and transitions that occur naturally in the passage through childhood, such as changing schools, teacher or home. Also, during significant traumas that can occur, when we can enable a child to process pain and confusion so that it does not remain stuck.

Another key departure from adult work is the importance of identifying the **contextual factors surrounding and having an impact on a child** – such as family dynamics, sibling rivalry, poor parental mental health, peer-group pressure and the school system, and factors such as cultural and religious values or how a child accesses counselling. All are vital in helping to identify what is needed and feasible. We must learn to be forever conscious of exactly what change is safe and possible for a child still living within the family.

Training must also encourage the exploration of our own emotional connection to the issues children present with. For instance, recalling our childhood experience of food and expressing how we feel about our own bodies can bring helpful insight into working with eating disorders. Activities around this in training provide a nudge and safe space to recall what we felt as a child, all too often forgotten,

Specialist training needs to include experiencing and sharing a range of creative and other interventions

and sometimes with good cause. And like all therapeutic training, this may reveal a need to take something to therapy.

The biggest challenges are often the greatest catalysts for change. In addition to reflective personal work, there is also intrinsic value in having to do **formal written work**. However much it may rouse our rebel Child, the inclusion of written assignments to achieve an **assessed qualification** helps to generate motivation and focus. It also enables us to discover more research, books and articles specific to working with children. Writing compels us to clarify our understanding and so deepen our practice.

Finally, we must understand and monitor the **risks to ourselves as well as to children**. An experienced, clinical supervisor with age-appropriate knowledge can help us do both, including keeping an eye out for any warning signs of vicarious trauma or burnout. Practising what we preach, through grounding, balance and genuine self-care also provides a good model for children.

Specific skills

In addition to age-specific knowledge, children's counselling calls for **a broader and more flexible skill set** than that used in most adult work. The need to engage and build trust with children of all ages, alongside their parents and other professionals, requires confidence and sensitivity as well as the ability to have fun – one moment, monkeying around with puppets, the next, speaking to the safeguarding team. Children's counselling demands good judgment and readiness to seek additional supervisory support as necessary, to help with what can be extremely hard decisions.

One example would be judging when and how we take information beyond the safe space of the counselling room. This must be consistent with how, in developmentally appropriate language, we have contracted with a child. **Clear contracting is crucial to the trust needed for success.** However, the increase in higher-risk behaviours has created more occasions when counsellors have to decide between maintaining a child's right to confidentiality under the UNCRC[10] and our duty of care as adult professionals to help ensure their safety. The growing risk of litigation can cause organisations and counsellors to share information too readily, and this may cause a child to end counselling prematurely, leaving them at even greater risk.

The effectiveness of **working systemically** is gaining increased momentum and is a significant departure from adult work. Since children do not exist alone, involving others in consensual ways that maintain respect for a child's voice, alongside one-to-one work, can often be the best route to sustainable solutions at home or in school. Inspiration can be drawn from established integrated models in other countries, such as the Australian Student Wellbeing Hub.[11]

Specialist training needs to include **experiencing and sharing a range of creative and other interventions**, such as therapeutic play, sand play, using nature, music, drama, meditation, visualisation and grounding – all of which can help to engage, process and heal. For anyone who has trained in a single modality, familiarity with the basic concepts from others, alongside the skill of **being able to adapt and combine different modalities**, can make us more effective with different ages of children in diverse settings. An exclusively talking approach is inappropriate with primary school children, and the

core conditions[12] of non-judgment, empathy and congruence appear essential to engaging children's trust, even within a time-limited CBT setting.

Strengthening professional confidence

The reality is that counsellors across all settings are working with **an increasing number of children presenting high-risk behaviours and mental health issues,** including self-harm, suicidal ideation, eating disorders, substance misuse and harmful sexual behaviours. Reflection on how we work with risk is now even more essential. NHS Tier 3 and 4 needs that would previously have been considered beyond our remit are now frequently in our hands. In addition to clarity and honest discussion around risk, resources like Reeves' *Working With Risk*[13] can help to develop competency for safe practice and increase our professional confidence.

People expect counsellors to be able to explain why children are in crisis. There isn't an easy answer, but we do know about the amount of insecurity and misery generated by the unattainable expectations and aspirations currently being fuelled by ubiquitous social media messages and images. These include subtle messages about how we ought to look, think or be, and 24/7 exposure to judgment and cyberbullying – not forgetting teenage male online porn consumption that is also distorting expectations of sex, bodies and intimacy. This, together with the decline in live, human interaction – which, as Bruce Perry[14] explains, simultaneously cuts us off from our primary source of biochemical 'feel-good hits' and reduces our capacity for empathy. These are just some of the factors simultaneously raising young people's distress and lowering their emotional resilience to cope with it. We can confidently use this information, where appropriate, in our dealings with parents.

The experience of training with a group of colleagues has the power to strengthen our sense of value and inspire renewed purpose. **In-depth, face-to-face training can help us more confidently communicate exactly what it is we do** and how we do it. In schools, as elsewhere, children's counselling is often misconceived as either 'a cosy chat' or a 'magic wand'. A network of trusted colleagues can support our confidence as professionals to demystify our work, disseminate skills for wellbeing, avoid isolation, and develop fantastic opportunities for collaboration.

No day passes without me feeling awed by children's capacity to survive the bleakest of circumstances and move forwards. Specialist training for work with under-18s enhances our capacity to offer them the healing support they deserve. I hope to have shown why this is not only worth it but ethically demanded.

*I use child/children in this article to refer to anyone under 18.

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WHAT DO WE TELL THE CHILDREN?

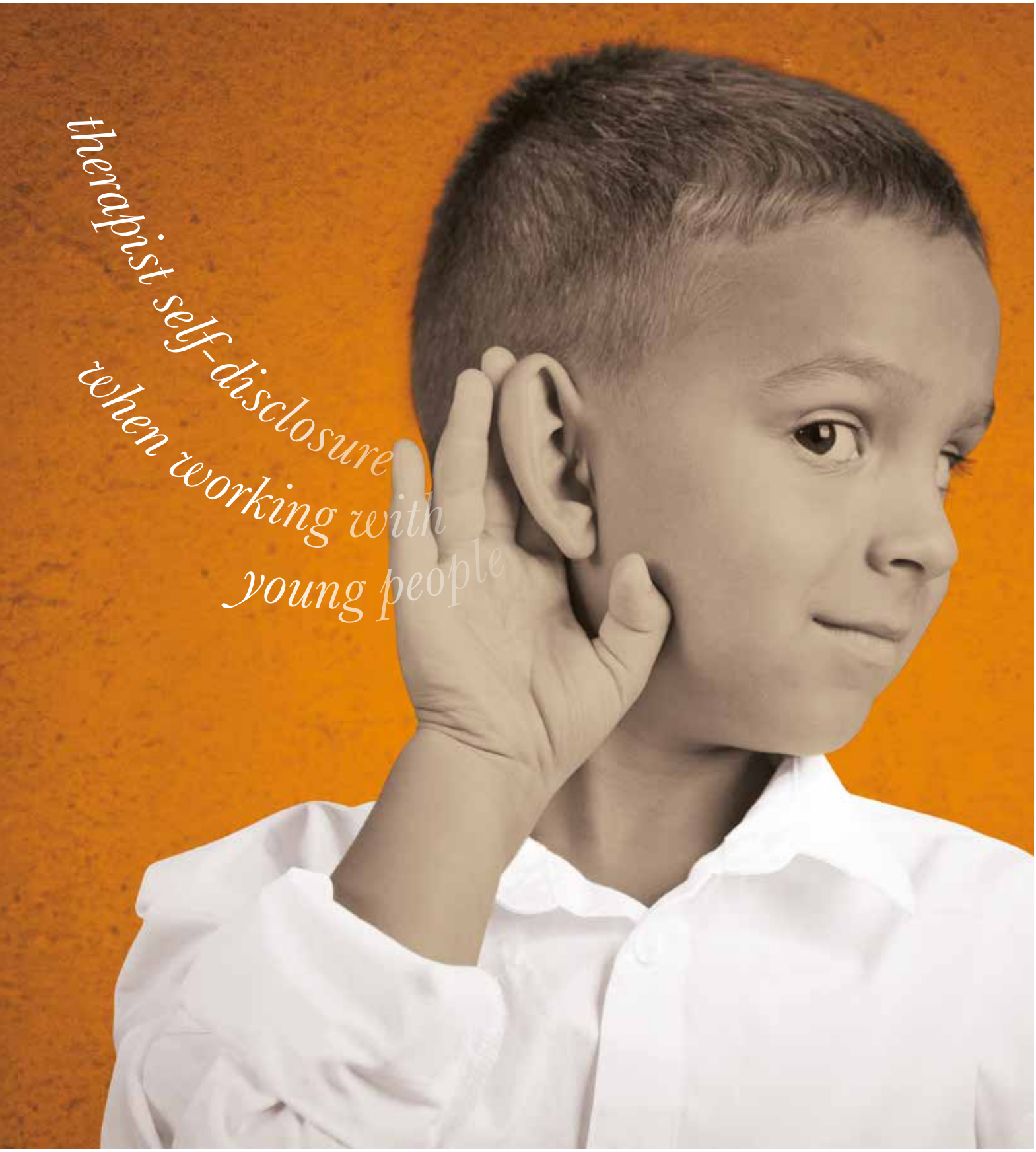
Colleen Swinden *discusses the dilemma of therapist self-disclosure when working with young people – taking her concerns from her own experience and the research she is undertaking*

For illustration purposes; posed by model

Working with adolescents and younger children in counselling can be hugely beneficial, and the creative resources available are often enjoyable and engaging for both therapists and clients. I recently came across a board game called 'All About Me'. When playing, both the therapist and the child follow the same rules: a dice is thrown, and the player moves along the board, landing on a square that instructs them to answer a personal question. The questions vary but will either be factual (Do you have children?), affective (What is the saddest thing that ever happened to you?) or behavioural (What's the naughtiest thing you ever did?). The board game on the course had no instructions, so out of interest I searched online for 'all about me therapeutic board game'. I found that it was very similar to another game called 'Talking, Feeling and Doing Game'.[1] Looking at the instructions, I could see that its creator suggested answering the questions honestly, but later changed this and instructed therapists to tailor responses to the needs of their child client. These later instructions suggest that the answers are less important – our willingness to self-disclose is what encourages reciprocity and can promote and enhance a therapeutic relationship.

However, the game did create a feeling of unease in me, because – other than for immediacy – I offer only a minimal level of disclosure, linked to breaks in my working schedule and general comments on starting or finishing times.

In support of those who *do* advocate therapist self-disclosure, I am sure they are not therapists who indulge in free association. In fact, Renik[2] suggests that if a therapist decides to disclose something to a client, the choice is made on the same basis as it would be in any ordinary conversation: what is the purpose of the disclosure? Is the disclosure likely to be understood as intended or is its meaning ambiguous? In addition, Renik suggests that to get children to engage in therapy, we need to speak to them in a way that has an emotional impact, and this could include dropping what has been termed 'third-person speak'. On the other hand, one reason



therapist self-disclosure when working with young people

There seems to be little research to support counsellors making informed choices regarding the appropriate use of therapist self-disclosure in our work with children

for not doing this and not self-disclosing is the idea that it blurs boundaries and sends mixed messages to the young client, making our therapeutic relationships seem 'real'. However, I know that a child with concrete thinking cannot 'see' us playing a role with certain rules or connotations; to those children, the relationship *is* real. Gardner,[3] in contrast, believes that younger children who have concrete thinking do require therapist self-disclosure as a model to process and quickly achieve therapeutic goals – which seems to support the use of the board game.

And the research shows?

As a counsellor who works with young people, I feel that there seems to be little research to support counsellors making informed choices regarding the appropriate use of therapist self-disclosure in our work with children. While researching this area as part of my doctoral thesis, I noted that Vondracek and Vondracek[4] suggest that children revealed more information to self-disclosing interviewers. Their research suggests that our behaviour scaffolds the young person's behaviour, as we partly put them at ease in unfamiliar surroundings and partly act as role models. It seems that disclosure begets disclosure and strengthens therapeutic relationships.

Beach et al[5] suggest that highly anxious adult clients would benefit from self-disclosure. As trained professionals, we can spot those children who are most anxious. But because the findings are from adult samples, the same may not be true in our work with young people.

This may partially account for why many therapeutic approaches see abstinence and anonymity as ideal. I am also aware that many therapists view self-disclosure as a lost opportunity to explore the child's fantasies about us. I am guided, though, by an awareness that young clients frequently come to therapy with a history of fixed and unyielding relationships. I worry that our patterns of deflecting questions could contribute to their experience of a world where they have less choice and autonomy, and this could give rise to our clients experiencing us as being authoritarian figures. This is a reasonable assumption if we stop to consider that much of the work we do with adolescents is also situated within their learning environment. My experience of working with young people shows that there is a challenge in maintaining a delicate balance between equality and authority. I acknowledge that, in answering their questions, I may fulfil the young child's immediate needs, but for me, the reality of finding ways of exploring why they wish to know those answers without alienating them can be a tricky path.

However, one benefit of therapist self-disclosure suggested by Eyrich-Garg[6] is that it can increase a young client's perception of similarity. In some situations, this similarity can increase a therapist's credibility. Answering yes to the question 'Do you have any children?' suggests that the therapist likes children – the child's assumption is perhaps that they will be a better therapist than one who is childless. I know from experience that this presents a challenge for those therapists who either will not answer those questions or who do not meet those personal specifications.

My reluctance and some dilemmas

I find myself reluctant to show similarity per se, but only because I am uncertain what client similarity will achieve. Bromfield[7] describes how, for him, frequently being asked if he had suffered the same childhood

disappointments, loses its effectiveness, or seems like a competition for the worst upbringing. I do not wish to be seen as being in competition with my clients. But my reluctance goes deeper than that. I worry that similarity may be inherently harmful and increase the danger of boundary violations.

For me, the *motivation* for self-disclosure should be a key element in deciding if it is an appropriate action: I need to ask myself what I expect to achieve. My reason for this is related to Williams'[8] research, which suggests that providing *advice* or *specific techniques* has been beneficial for adolescents receiving counselling. It would seem that we are now creating a paradox, between adolescents needing to explore their identity and autonomy and a more direct solution-focused approach – because certain suggestions and techniques are a form of self-disclosure too. My concern is increased when I see this through the lens of Williams' research, which tells me that if a client feels too similar to their therapist, they may act quickly on any recommendations they feel are being made, without genuinely considering how the recommendations will fit *their* unique circumstances. If my motivation for self-disclosure is to use it as a tool for persuasion, this may seem to be in the best interest of the client. However, when working with adolescents, this may easily tip the power balance and rob them of their right to make decisions for themselves. This creates in me unease and a sense of risk, without offering any clear therapeutic gain. The ethical dilemma involves the competing principles of autonomy and beneficence. Proctor[9] guides me by highlighting how contemporary Western society's ethical laws prioritise autonomy above beneficence, believing the client is capable of deciding what is best – a good example of this being the idea of 'Gillick competency'.

I am also apprehensive because it is difficult to gauge how young clients will perceive my self-disclosure. I could have the best motivation, yet the smallest of disclosure, the merest flicker of a facial expression, a shifting of weight in my chair, a change in voice-tone or breathing, blushing or averting my eyes could all give away my thoughts and feelings. Derlega, Lovell and Chaikin[10] looked at the complexity of clients' reactions to self-disclosure and found that clients who expected therapists to self-disclose would reveal more information to a highly disclosing therapist. Conversely, clients who viewed therapists as *unlikely* to disclose tended to reveal less to a highly disclosing therapist. This suggests that preconceived ideas of how therapy works, and what good therapy should look like, is the basis for our clients' reactions. I have learnt that, for many clients with diverse backgrounds, therapist self-disclosure may be viewed negatively – as an intrusion – making the therapist seem overfamiliar and unprofessional. However, when working within some cultures, therapist self-disclosure may be an important element to gain trust and develop a strong working alliance. Barnett[11] highlights how our use of self-disclosure with clients of diverse backgrounds is an essential part of our competency as counsellors. So exploring the child's ideas of therapy at the onset could provide valuable information to form the basis for our use of self-disclosure in sessions.

I am aware that, for me, therapist self-disclosure means questioning my practice

Further thoughts

There have been very few studies that have directly assessed the *effects* of therapist self-disclosure on children in therapy. Capobianco's[12] research states that therapists reveal personal information to child clients infrequently, and that child clients rarely solicit personal information from their therapist. He also adds that therapists of those who are under 18 seldom believe that their disclosure advances their client's treatment aims – which certainly made me see the board game as having less relevance therapeutically.

Eyrich-Garg's[6] study explored, from the client's perspective, ways to engage and build positive therapeutic relationships with adolescent girls. The study was conducted with residents at an all-female emergency shelter where they received ongoing, weekly counselling sessions for the duration of their stay. The study asked: 'If you could tell a counsellor anything, what would you tell him/her?', 'What do counsellors need to know?' and 'How can a counsellor get you to talk?'. Several themes emerged from the clients' responses, and included 'a need to be listened to', and 'to be respected and treated as equals'. They wanted therapists to 'tell me what you are doing' and 'tell me a little about yourself'. Many of the girls had been alienated from their families and had probably worked with a multitude of professionals. They had strong views on counselling and its value. The study showed that attempting to build a therapeutic relationship in a rigid, hierarchical manner would greatly impede the work. Gil[13] stressed the importance of not getting into power struggles with clients, as those who have been maltreated can often see their counsellors as extensions of their parents, who are in positions of power and have control over

Without a conceptual framework, the use of self-disclosure remains subjective

them. Although the girls did suggest therapist self-disclosure as a concrete strategy to encourage engagement, it is, however, feasible that the group would still fail to engage if all strategies were followed, as they still might not wish to share any thoughts and feelings with other adults. However, the study does suggest that in taking a stance of relative anonymity, we may be protecting ourselves at the client's expense. It would seem that working with young people who have a difficult background requires therapists to endure a measure of exposure that goes against longstanding, even currently prevailing, views in our field.

However, without a conceptual framework, the use of self-disclosure remains subjective, and, regardless of their cultural background, a young client may not want to hear about my views, personal issues or my past. My self-disclosure to aid our therapeutic alliance may easily become excessive and burdening, or even tip over into role reversal. One strategy to help me assess the situation is to stop and specifically ask the young client whether it would be acceptable to them if I were to share a personal experience that I feel might be relevant and, hopefully, helpful to them. Young people should have the right to make that decision for themselves, and they might be quite receptive to the idea – or they might decline. But in both instances, the young person will probably value the respect I have implied by offering them the choice.

I feel that with so many variables of age, gender, race and background, it can never be a clear-cut all-or-nothing decision. There are simply not enough studies to reach any conclusion, and I am left worrying about the underuse or misuse of therapist self-disclosure. I know from experience that, without a safe place for discussion, we are left to struggle alone over what is 'unprofessional', what is 'beneficial', and what is basic human interaction. I am aware that, for me, therapist self-disclosure means questioning my practice. In a profession where we are increasingly encouraged to work as equal partners with clients to overcome problems and help with recovery as defined by our clients, I frequently wonder:

- Should we be behaving differently?
- Is opening up and sharing our frailty, vulnerability and anxieties something to consider?
- Would focusing on our resilience be beneficial to those who have temporarily lost their own?
- Is it ever appropriate for therapists to talk about themselves with clients, and could this even be beneficial?

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Living with disappointment

Nick Luxmoore *allows us to witness a supervision session where the idea of disappointment – with parents, children and even supervisors – comes to the fore*

Caroline's displeased. Any comments that I make in supervision about the young people she's seeing for counselling appear to be misplaced, misconceived, as if I'm always misunderstanding her and them.

She sighs. Looks down at her notes again. Says nothing.

I've tried to raise my supervisor's game by concentrating fiercely, tuning in as never before, deliberating for longer before saying anything.

And yet still I seem to be getting it wrong.

'It's not really like that,' she says, or 'I don't think that's quite what I mean.' She sometimes lets me finish before concluding: 'Yes, but that doesn't apply in this case.' Or she'll simply say: 'I don't think you've understood.'

I'm left feeling useless, as if I'm a terrible let-down. And it's a familiar feeling. Over the years, I can think of several young people with whom I've had good, fond relationships who've suddenly taken against me for no obvious reason. I know that I'm more than capable of making mistakes – plenty of them – but on these occasions, unless I've been fooling myself, I've done little to deserve the sudden change in the young person's behaviour: shunning me, avoiding eye contact with me, speaking scathingly about me. And now, here's Caroline, a counsellor, who until fairly recently was coming enthusiastically to our supervision meetings, writing everything down and claiming that these sessions were just what she wanted. Clearly, she now feels differently.

I ask whether she's still finding the sessions useful.

'It's not that,' she says. 'There's nothing wrong with our sessions. It's just that we never seem to get anywhere. We keep going round and round the same old things.'

I wonder to myself how much her original enthusiasm about supervision was based on an idealisation. Evidently, I was once a supervisor who *did* understand, who *did* believe in her, who *did* leave her feeling optimistic at the end of sessions. Maybe now she's disappointed because I haven't lived up to that billing? And maybe I never could have lived up to it if the billing was unrealistic? Maybe that was my mistake: allowing myself to bathe in her admiration, allowing her to go on believing that I had the answer to everything, that I'd always be able to understand her and her clients?

'We never seem to get anywhere,' she repeats. 'It always comes down to the same old things that we've talked about before.'

I take this to mean that I keep repeating myself, that I've become boring, a disappointment to her.

Counsellors work constantly with disappointment because disappointment is at the heart of every young person's experience. Theoretically, disappointment begins from the moment of birth when a baby first experiences a mother who *isn't* always there, who *doesn't* always understand and who *can't* always live up to the implicit promise of a womb: 'I'll always be there for you! I'll keep you safe and warm! I'll anticipate your every need!' Theoretically,[1]

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the baby-child-young person splits its mother into the good mother who provides and the bad mother who doesn't – two mothers – and then spends a lifetime trying to come to terms with the fact that these two mothers are one and the same person, neither as good as the baby hoped, nor as bad as the baby feared. Just disappointing. And this sense of a disappointing mother extends to everybody else. Young people are disappointed with their fathers and with their siblings. They recruit friends to replace these disappointments, but after a while, their friends become disappointing as well. And all sorts of other people fail to live up to expectations: teachers, for example, and counsellors. The most disappointed young people were probably once the most hopeful, but, without opportunities to make sense of their disappointments, the danger is that young people become embittered.[2]

Ultimately, young people are disappointed with *themselves* for failing to live up to their own expectations, and that's especially hard for them to bear, to forgive, so they project their disappointment onto other people, railing against everyone *else's* shortcomings: against teachers who don't understand, against counsellors who can't stop bad things from happening, against The Whole World for being imperfect. I wonder to myself how much Caroline the counsellor, on the receiving end of young people's disappointment, takes that experience and passes it on to me in supervision; how much I become the disappointment so that she doesn't have to be?

I tell her that I've been thinking a lot about disappointment lately.

'What about it?'

'Well, about how we're obliged to disappoint our clients and about how so much of our work is helping young people tolerate disappointment as an inevitable fact of life, as something that we feel about most things most of the time. I was thinking about how young people, in effect, are always telling us a story about being disappointed, and a story about how unfair that disappointment feels.'

Caroline's giving nothing away.

'About how young people are sometimes driven to extremes of behaviour in their attempts to overturn their disappointments, to rid themselves of the disappointing people in their lives, to transform disappointing situations.'

'Or sometimes they give up,' says Caroline, 'if something can't be perfect. Like a boyfriend or girlfriend. Or an ambition, if it's hard to achieve.'

I ask if she has a particular young person in mind.

'Lots!'

'Like who?'

She tells me about Sigrid: not someone we've talked about before.

'Originally she came because of anxiety, but I think she's actually really angry. The trouble is that she's supposed to be this nice girl who doesn't complain, does as she's told, tries hard at school and gets really good grades. Which is what her parents expect. But she's started seeing through all that – wondering whether her parents do actually care or whether they're only interested in her grades. And from what she says, they do sound spectacularly uninterested in anything other than grades. She says they only ever ask about schoolwork, and so, not surprisingly, she's pissed off. I think her so-called 'anxiety' is her anger struggling to get out. And struggling to stay hidden.'

What Caroline's saying makes absolute sense, so I keep quiet. But she's stopped talking now, as if expecting me to interject.

I say that her hypothesis sounds extremely plausible. She looks pleased. I ask about the link she's

making between Sigrid and young people who give up when they're disappointed.

'Well, I was thinking that if she's always tried to please her parents, and if that's started to feel hollow, maybe she wants to give up on them; maybe she can't find a way of living with them now that they've turned out to be disappointing. Like most parents turn out to be disappointing.'

'And like most supervisors,' I add quickly.

She looks embarrassed, pausing, taking stock. 'Are you implying that I find you disappointing?'

I decide to say what I'm thinking. 'Yes, I am implying that, Caroline. And I'd be surprised if you *didn't* find me disappointing, at least some of the time.'

'Why?'

'Because people always disappoint each other. It's inevitable.' I tell her about Schafer's idea of 'defensive disappointedness'[3] whereby, feeling ourselves becoming dependent, we recoil because the prospect of depending on anyone will eventually mean being disappointed by that person, the way our parents once disappointed us as babies. And because that remains a painful memory, we sometimes retreat from potentially good relationships in order not to be disappointed, not to be hurt.

'So you think I'm disappointed in you? Is that what you're saying?'

'I am saying that, Caroline. I think you're disappointed, the way we're always disappointed when we have high hopes of someone; the way Sigrid might be disappointed in her parents and the way they might be disappointed in her.'

'So you might be disappointed in me!' she says.

I'm not sure how to respond. I *am* disappointed in her and for all the wrong reasons. I'm disappointed that she's been giving me such a hard time lately. I'm disappointed that she's no longer my meekly admiring supervisee. I don't want to admit these things to her, though, because I'll be admitting to my own vanity. And yet how can I expect Caroline to admit to any disappointment in me if I can't admit to my disappointment in her? We expect young people sooner or later to find fault with their parents as an inevitable part of adolescent development. We don't expect long-suffering, saintly parents to be personally disappointed in the children they love. And yet the child never entirely lives up to the parent's expectations any more than the parent lives up to the child's expectations.

'In a way, I am disappointed in you, Caroline. Disappointed that you've grown up as a counsellor and no longer need me like you used to need me… But I'm also pleased that you've grown up and no longer need me like you once did.'

She looks relieved. 'Thank you for saying that,' she says. 'You're right. I have been feeling disappointed with you. Very disappointed. In fact, I've been thinking of changing supervisors. But I wouldn't want you to think that I haven't valued our work together because I have.'

We look at each other, neither of us knowing what to say.

'Maybe we should start thinking about you moving on to another supervisor,' I say to her. 'For good reasons. Because you're ready.'

'Now I feel bad,' she says, 'as if I've bitten the hand that's been feeding me.'

'Maybe that's what separation always feels like,' I suggest. 'We know that we're going to get new things but we're also losing old things that may have been valuable. Maybe separation's always bittersweet.'

'Maybe Sigrid's parents are disappointed in her,' Caroline says. 'Maybe she senses that and maybe that's partly why she's so angry with them.'

I say it's a good thought.

'It's the old story,' she says, smiling and gathering her notes. 'If only we could work with the parents!'

Nick Luxmoore's latest book, *Practical Supervision For Counsellors Who Work With Young People*, (Jessica Kingsley Publishers, 2017) is out now. www.nickluxmoore.com

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Shaking the tree

Laura McDonald *looks at the importance of considering family relationships when counselling with young people. The influence of home is never absent*

Donald Winnicott famously said that 'there's no such thing as a baby'[1] when describing the interconnectedness of mother and child in the earliest stages of life. Although we grow up and away from this early stage, it's often difficult to establish where family influence begins and ends, for ourselves and our clients. Some counsellors will be working with primary school children, but many will be seeing clients who are negotiating (in every sense) their adolescence. We recognise that adolescence is the second time round for the stage of separation and individuation from family experienced by the young child – that of 'me' and 'not me' described by Winnicott[1] – which makes it necessary to 'shake the family tree' to see what falls before automatically seeing the client only as an individual.

So what *do* parents hand down to their children? To give an example, one of the issues I encounter most as a school counsellor is anxiety. Clients claim the anxiety as their own, but often I'm not so sure that it belongs to them alone. In practice, the conversation might go something like this (let's call our hypothetical client Claire). Claire is just starting in the sixth form and has come to see me because she is feeling anxious 'about everything'. Around the third session, I suggest to Claire that she doesn't seem overly anxious. In fact, she comes across as a sensible self-possessed young woman who seems to enjoy taking charge of situations when her friends are in difficulty. Claire takes a deep breath, sighs, then tells me of a time when she was younger and she didn't want to go to the shops with her mum. It was a long time ago and Claire can't remember why she didn't want to go or what emotions were in play. What Claire *does* remember is her mum tutting and saying: 'You always were an anxious child!' In those six words, a spell was cast. Now, whenever Claire feels uneasy or confused, she attributes it to her anxious inner child. She doesn't at first believe me when I tell her that a certain level of adult anxiety is normal – healthy, even. I recount to her some of the situations she has described being in herself, of how competently she handled them, and of the support she gives her friends. Claire looks confused, then relaxes and smiles.

Part of my role in schools and colleges involves giving talks to staff about how they can help young people in their care. These teachers and support workers are dedicated to the pastoral side of their work, but often feel nervous about how they exercise it. Something that comes up a lot in discussion is the question of experience. Adults often feel that they have plenty of experience to share – but can feel frustrated when young people reject it.

My job then is to help them think about what is happening here. Blos[2] points out that during the latency period, before true adolescence begins, feelings of self-worth are obtained less from our parents and more from having our own achievements recognised by others. This shift is not always easy to manage, and occasional misjudgements can cause huge embarrassment to young people. The tendency for regression is high when they move away from the close family culture into unknown waters, but later on, 'significant ego activities such as perception, learning, memory and thinking become more firmly consolidated into the conflict-free sphere of the ego'.[2] In other words, our young people, through experience and observation, begin to acquire their own wisdom.

So when teachers attempt to pass on *their* wisdom, they often replicate a parental/societal transference that the young person is trying to challenge or escape. Our job is to maintain the developmental space and use our insights to explore directions and choices with our clients. This is a privilege of the therapeutic alliance that makes it markedly different from the directed-ness of school or home. If this space is *not* observed, the transference will assert itself as negative, creating a tendency towards acting out and resistance, but lacking the essential opportunity of working through. Of course, both we and our clients always run the risk of mutual rejection, and occasionally this is extremely therapeutically useful, provided the therapeutic alliance can be maintained – but not so if the young person subsequently feels too ashamed or overwhelmed to continue, and so becomes unable to pursue the therapeutic alliance.

Most young people start with the internalisation of a good object. Not only do we depend on the caregiver for our physical needs, but he or she also safeguards our emotional wellbeing by processing bad feelings for us. Perhaps the later anger at parents is about loss and disillusionment – because parents can't always make things better. So we need to remember that teenage anger expressed in our rooms is as much about loss of childhood as it is the perceived lack of freedom, voice, or respect from their early caregivers.

Tight family machines and the fall-out

Jaques[3] refers to individuals as 'cogs' who make up the family 'machine'. I have also observed, when shaking the family tree, that in order to overcome the challenges of everyday life, a family machine can become so tight, so inflexible, that the wobbly 'cog' (my young client) has become the subject of unconscious blame from the rest of the family. The child's reaction to this barely detectable disapproval is to introject it, along with the feelings of 'badness' inherent in the developmental crisis itself. This unconscious desire of a family or organisation or, more recently, society, to 'fix' a problem in its midst by 'tightening' is partly characterised in the tendency to seek medical diagnoses and treatments for difficult adolescent behaviour. Adopting a medicalised approach provides instant relief by removing guilt. The subject can't help their condition, the parents can't be blamed and everyone goes home feeling better.

What Claire does remember is her mum tutting and saying: 'You always were an anxious child!' In those six words, a spell was cast

Sometimes, though, there are rewards for merely enduring the discomfort of adolescence, such as the concept expressed by Freud as 'self-mastery'. I wonder if, by attempting to ease our path with medical diagnoses and pathologies, we have actually made things harder to understand. In Freudian and Kleinian theory, 'far from soothing the psyche or the self or dismissing the guilt as unfounded, the analyst seeks to make conscious its unconscious, real or imagined grounds'.[4] The trouble is that children who have not learned self-mastery become parents unable to tolerate the psychic upheavals in their own infant and adolescent children. Remember, that if adolescence is the re-enactment of infancy, the most potent opportunity of the primary caregiver is the provision of reassurance and developmental space. If this is lost, if the parent cannot bear and absorb the child's cries, but interprets them as sharp and accusatory, the child cannot then model self-mastery.

It follows that teenagers who feel both invincible and abandoned – often characterised by self-alienation or a nihilistic outlook (think 'Emo' or anarchic tendencies) – are perhaps experiencing a reprise of the 'terrible twos', trying to exercise their autonomy in the family while at the same time fearing abandonment. The self-consciousness of growing up, the stretching of familial bonds, when parental aspirations are swallowed up along with the limitless potential of childhood: this is the place where young people look for their own meaning, determined to find the truth of their existence.

So this is what I like to explore in my practice – the duality of adolescence and family. It's a sliding, shape-shifting thing that moves quickly together and apart again, never quite resettling into what it was before. It's both traumatic and beautiful to be part of. As you might imagine, I encounter many relationship 'styles' when working with young people. It's common to observe the reactive/preverbal communication between father and son, or the verbal/emotional bond of mother and daughter and, of course, all things in between.

Relationship templates from home

Relationship templates derive from family life, and may or may not work outside the family environment. Conflict and conflict resolution styles especially, are learned first in the home, often leaving little room for developing children to adapt and improvise. During adolescence, we begin to challenge our parents' way of relating and try different approaches. These new approaches may be formulated from books, TV, movies and games, or time spent with friends in their family home. The observation and reformulation of established mores can bring a great feeling of relief for those who feel different from their own family – and which of us *hasn't* had a profound feeling of difference and being grossly misunderstood in our teenage years? It's not uncommon for younger teenagers to inhabit some form of adoption fantasy, hoping to be 'rescued' by idealised 'real' parents who will truly understand them. Here again, we can provide a space during therapy to compare and contrast realities, unconstrained by family values and loyalties.

Parents can feel terribly rejected by teenage tantrums and anger. So it's important to promote the idea to our young clients that this is part of the teenager's rejection of self being projected onto those closest to them. This new order of things is a disillusionment for both parties. It's difficult to sit in the destruction zone as a parent and imagine all is well, and I often invoke Winnicott's assertion that 'no one would claim the word "health" is synonymous with the word "ease"' as a welcome piece of wisdom to offer.[1]

Although we attribute a lot of power to peer pressure among teens, in any group – including school and family – there is pressure to fit in. This is the world that adults dwell in: timetables, meetings, work, planned holidays. Fitting things in is essential to daily functioning – if someone isn't fitting in, it throws things off balance and causes insecurity in the group.

When teaching groups of trainee counsellors, I notice a tendency for the trainees wishing to work with children to stick with me and those wanting to work with adults to find another tutor to adopt. This interests me, because I know that an awful lot of the work I do with adults revolves around their own struggles with childhood and adolescence. Jaques[3] points out that by the time their children reach adolescence, parents will usually be in a relatively stable period in their lives, which should make it easier to work through their children's turbulent teens together. But I wonder if this doesn't sometimes compound the 'rude awakening' of parents who feel they had been getting things pretty much right. Jaques[3] does, however, concede that parents going through emotional or relationship difficulties may experience teenage upheaval as the final straw, and in these circumstances the projection of unhappiness can make it feel like a perpetual cycle of blame, making it impossible to tell which cause and what effect belongs to whom.

There are, of course, parents (of our young clients) who themselves failed to negotiate adolescence successfully, and we need to watch out for and recognise this. Sometimes they were deprived of the freedom that their own children seem to enjoy, and they want to 'join in' on the fun in some way. But what do you do to rebel as a teenager if your parents want to be like you? Alternatively, parents who feel they didn't make the most of their education might decide to set impossible standards for their children as a way of repairing their own past mistakes. But adolescents' capacity to deal with life challenges depends on their inner resources, and these develop from earlier relationships with caregivers and need to have been healthy, which is why we shake the tree and see what falls.

However, sometimes, an older or more distanced family member can 'draw the heat' from those parents who are fraught with arguments that go nowhere and sap energy from family life. I've frequently heard about grandparents providing a safe haven for my adolescent clients. The vital ingredients in this healing relationship seem to be time and non-judgment. It can also be, if introduced subtly, a place where adolescents find out from someone who was there at the time that their parents were also difficult teenagers. Rodriguez[5] observes that in times of family upheaval or conflict, where extended family members are unavailable in some way, the therapist, too, can represent a stronger, safer object than their parents.

The upshot of shaking the family tree is this: that although it's perhaps instinctive to collude to some extent with the 'misunderstood' adolescent, however much we wish to respond to them as individuals, we cannot escape the fact (and neither can they) that they are a product of their family and environment. Using what we learn about the therapeutic alliance in family therapy can throw up some interesting pointers. We can involve parents to some extent, and this can be helpful in alleviating splitting behaviour in parents and children alike. And moving from thinking about a 'problem child' towards an understanding that the whole *family* is facing change can be extremely useful in addressing the reciprocal anger, fear and disappointment we encounter in our young clients.

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Lost in the lands of feelings

Visual navigation, orientation and practical emotional cartography help ***Charlie Morse-Brown*** *and her clients on their sometimes surreal odyssey through therapy, moving from not-knowing, to awareness, to knowing what to do with that awareness*

Everything moves.
Everything develops and progresses.
Everything rebounds and resonates.
From one point to another,
the line is never straight.
From harbour to harbour, a journey.
Everything moves... as do I!
Joy and sorrow, confrontation too.
A vague point appears, hazy and confused,
A point of convergence,
The temptation of a fixed point,
In the calm of all the passions.
Point of departure and point of destination,
In what has neither beginning or end.
Naming it, endowing it with life,
giving it authority
For a better understanding of what
Movement is.

Jacques Lecoq, August 1997[1]

Arguably therapy is a process of getting to know yourself better, getting to know the edges and borders of your thoughts and feelings, and therefore growing a better understanding of your behaviours and motives.

A lot is written about the therapist's role in containing emotions, facilitating the client's emotional process and thus enabling them to be more aware of their emotions. In my initial sessions with clients, I talk about the collaborative nature of therapy – how I will accompany clients on their journey as they navigate the land of emotions to gain this understanding of themselves. I explain that they're in the driving seat, with their foot on the pedals; they can speed up, slow down, stop when they want; and that I'm in the passenger seat with the map, and I'll maybe make suggestions like *how about exploring that dark forest over there?* or *what about a trip to the mountains?* I watch the process, sharing my observations and postulations with the clients.

Travelling on this surreal road trip together in a therapeutic microclimate, client and therapist co-create the narratives around where we find ourselves, wondering about where these emotions originate, investigating what the feelings may need.

I explain that sometimes the process of therapy can feel like an odyssey – a long and arduous journey. That as we near great heights of new understanding, the moments of jubilation may well be starkly contrasted with times of dread, confuddlement and an unending sense of lost-ness. In my experience, this is especially resonant when working with children of five to 11, who are almost always in the present moment of industrious play but who aren't developmentally able to reflect on what's happening – so, in this case, the world is very vague. And as the therapist, in a very real sense we hold the unknown.

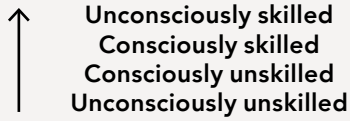
Bowlby wrote about the therapist's role as a secure base from which the clients are brave enough to explore and investigate new territories.[2] With this exploration, we will hopefully glean insights into our feelings.

In his work on sub-personalities, Assagioli[3] would agree that an important aspect of the work is to give each client a sense of understanding *all the aspects of self* that prompt and motivate feelings and behaviours; believing that as soon as there is an understanding, we have choice and mobility, almost a metaphorical passport or identity card that enables us to travel through the borders of emotions and ingrained character defence mechanisms. We can choose how we integrate them into the wider context of a journey. We are working towards open borders with a freedom of movement and an ability to travel into – and out of – feelings and patterns of behaviour.

Some of my best critics are the adolescents I work with – they have a canny sense of reality and regularly deploy their 'bullshit-ometers' to keep me from becoming too much of a pashmina-wearing, platitude-repeating cliché of a therapist.

I've had countless sessions in which I've felt a temporal shift in understanding. Perhaps the insight is microscopic but it is one that could produce a seismic shift in the client's behaviour. As I reflect back to them the potential power of the insight, I'm often met with adolescent cynicism: 'Well, what do I bloody do with this awareness?' Or: 'What good is the awareness to me if I don't have any set answers on how to change it?'

I sometimes use the hierarchy of competence or learning stages with older clients – how it is that, now we have an awareness of what we don't know or can't do (consciously unskilled), we are able to develop new knowledge.[4]



As she talks, she seems to talk round and round in circles. She is technicolour, surround sound, full on. She also seems to be on a continual tectonic shift. Each week, different, urgent crises come into the room

The gap between consciously unskilled and consciously skilled can feel like a real no-man's-land. There is a chasm between awareness and knowing what to do with the awareness. Sometimes it's too huge to bridge and there is a time delay between that awareness and gaining the ability to choose an alternative behaviour or course of action. This can be an incredibly turbulent time, with fear of stagnation and frustration that things aren't changing quickly enough. And this turbulence can come from both the client and the therapist in a heady mix of transference and countertransference.

It's hard for therapists when clients bring their anger into our relationship, when they question the blind, not-knowingness of the therapeutic process. Having been a client, I have felt that anger – the lack of solidity: 'So with this new awareness, what do I get, other than a deepening sense of how much I don't know, and can't change? An awareness of how bleak things truly are.' I don't have any substantial answers, just the hope that through better understanding, we will eventually arrive. I'm armed with the time-served therapy cliché about 'trusting the process'. But this is hard. It's hard to trust. It's hard to be patient when you're in pain. We're working with paradoxes.

Map making

So I have found that, when we're in uncharted territories, awash with contradictory feelings and a sense of lost-ness, working with map making is a practical and reassuring process.

Sometimes I'll ask clients to draw out maps, to chart where they are now, where they have come from and where they are going. Sometimes I'll ask them to populate existing maps with their emotions, to colour, collage or paint their feelings into the map. The image at the head of the article is mine, but is inspired by some of the clinical work I've done with map making. Strangely, there is often a real parallel process that occurs between client and therapist; it's a grounding experience when we find ourselves with something to orientate to.

The door to the counselling room swings open, and Jerry rushes in, already saying: I'm just so confused,' as she flops on the sofa. 'Whatever I say or do seems to be the wrong thing everywhere. This week I've had huge fights with my family – even my sister. Don't get me started on school – every teacher has told me off or given me a detention – and then there's all the stuff with friends…' (she sighs, dramatically) 'Friends have been a rollercoaster this week... It seems like everything's going wrong, and I don't even know why. I'm feeling so many emotions I can't even begin to tell you what I'm feeling.'

I'm a fan of Jerry. She's 14 years old, super expressive, always wearing quirky earrings – some weeks she has lots of bracelets, other weeks she has none. Her clothes are always unpredictable and surprising, and she wears lots of different perfumes – all of them strong and lingering. She's expressive in every way possible. Often she brings with her a sense of overflowingness, like she's in sensory flood – which I often think is an externalisation of how she feels inside. Sitting in the session, I can almost hear my supervisor saying: 'OK, Charlie, what's the therapeutic task here – what is Jerry working towards?'

That's the thing – some weeks it's so clear to me – and other weeks, I, too, get lost in the torrent of feelings that flow from her, finding myself in the no-man's-land of not-knowing, of having to hold onto the unknown and have faith that, through these sessions, we will come to a clearing, arrive at a deeper understanding of where Jerry truly is.

As she talks, she seems to talk round and round in circles. She is *technicolour, surround sound, full on*. She also seems to be on a continual tectonic shift. Each week, different, urgent crises come into the room. She is consistently baffled by the situations that happen to her in the outside world and the feelings they leave her with. She's consistently shocked by feeling out of control. But in my session with Jerry today, I think I have a good grasp of the task – we're working towards her better understanding of her feelings, where she begins, where she ends, what part she plays in her encounters with the outside world. We are working towards defining her edges and her emotions. I have a sense of needing to pin things down, so when she comes to a natural pause, I ask: 'How would you feel about doing a bit of art today?'

'Yeah, sounds good, shall I get the paints?'

I nod and pull out from my desk tray a map. I explain: 'Everything sounds a bit muddled and confusing at the moment. So I thought you could paint the shades and colours of all these overwhelming feelings onto the map, placing them

next to one another and marking out their borders and edges. Is that clear?'

She settles into the task eagerly, and a quiet focus descends on the room. We're absorbed in the task at hand, Jerry painting, me witnessing what emerges. I watch as she mixes colours, overlaps them, blurs the edges. Once the paper is covered in colour, she exhales deeply. I follow her lead and ask: 'So can you talk me through it? Label some of these land masses with names, emotions and feelings…?'

As the paint dries, she talks me through what she's made. Captured on the sheet of A3 is a whole array of contradictory and complicated feelings. But somehow, as she talks, she is quieter, gentler.

'What's it like seeing them all there on that paper?' I ask.

'Well,' she sighs, 'It's no wonder I feel hectic, is it? There's a lot going on, isn't there?'

In my former years, I studied the Lecoq pedagogy of physical theatre.[1] One of my fondest memories was when we studied chorus and ensemble playing. Faced with the topic of deep, Greek tragedies, we learnt to move in flocks. A whole body of people underpinning the hero on the stage. The chorus moved as one, resonated, breathed, as though we were a whole organism. Central to chorus work was the need to contrast with the hero. The chorus would stay still as the heroine would move, the ensemble would dart stage right as the hero slowly entered stage left. It was an interplay – a sense of balance and counterbalance, movement and stillness, silence and sound. Lecoq wrote that in every shoal of fish, there is always one stationary fish, one that will be the fixed point as the others move around it.[1]

I often find myself acting as a counterweight, breathing to regulate emotions, containing the frustration, being still in times of movement. The epitome of this is 'trusting the process' even when we feel completely lost

To me, there's a parallel in therapy work. I often find myself acting as a counterweight, breathing to regulate emotions, containing the frustration, being still in times of movement. The epitome of this is 'trusting the process' even when we feel completely lost.

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OPINION

JEANINE CONNOR

Reflecting on... SUGAR BABIES

You've heard of sugar daddies: rich, older men who pay for the company of attractive women. Sugar-daddy websites were around long before more mainstream dating apps, but the quantity and quality of them is shifting. BBC Newsbeat[1] recently reported that one site had over a quarter of a million university students registered as sugar babies, a rise of 40 per cent in 12 months. The dating choice of consenting adults is their business. Therapy referrals have made sugar daddy-ing part of mine.

There is a sinister clue in the vernacular: barely pubescent sugar 'babies' are accepted onto websites by uploading provocative photographs and fake ages. They provide company to rich men for money, and by 'company' I mean sex. The younger, more attractive the girl and the more niche the sex, the higher the price tag. To be clear: if you're 13 and willing to be caged, gagged or participate in anal or sadomasochistic sex, you can earn big bucks.

Legalities and safeguarding aside, I see my role as helping these girls to think about their choices. Many insist they don't want to stop sugar-daddying. They reason that it's the men who are being exploited and they who are in control. They see their age as their weapon; if a man gets too rough, they threaten him with the charge of sex with a minor. It's a dangerous game. They switch off, engaging physically but not emotionally. The effects of this inevitably filter outwards, making 'normal' relationships impossible. An 18 year old I worked with told me she'd never been kissed, although she'd had sex with scores of men since she signed up as a sugar baby aged 14. She's been beaten, whipped and asphyxiated for other people's sexual gratification. She earned enough money to pay her way through university, but, in her own words, it f***ed [her] up.

We need to be willing to ponder sex with our young clients, including depraved, immoral and illegal sex, in a way that helps them to ponder it too. Their best defence has been to not think. If we pretend it's not happening to *our* clients, we collude. If we share disclosures and report abuse without exploring it with the girls themselves, we risk losing them. If we cut off psychologically, we mirror their cut-off-ness and they remain stuck. The way to change the unthinkable is to think about it. Now.

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ALISON SMYTH

Thinking about... THE UNSPEAKABLE

Clients of all ages can often find it difficult to engage in dialogue or creative interventions in the therapy room. Resistance to the therapeutic process – from fear, anxiety or uncertainty, or from mandated or enforced attendance by social services or parents – can leave children and young people especially cautious about trusting a stranger. Our job as therapists is to build this relationship by entering the child's world and meeting them within it, to facilitate their understanding of their current difficulties or challenges. But what if the child remains silent?

Gail brought such a case to supervision. Her extensive experience of working with trauma within a community setting meant that she was highly skilled and certainly no stranger to such presentations. Her understanding of trauma theory underpinned her firm belief in the body's capacity to 'keep the score'. However, she became aware of a sense of being utterly overwhelmed by a particular child, who had been referred for school refusal by an Educational Welfare Officer (EWO), and by this 11 year old's resistance to engaging.

The girl would arrive promptly, having been brought by her father, and simply would not respond beyond the most superficial dialogue. Previous personal therapy and our longstanding supervisory

relationship meant that Gail and I had often discussed Gail's resonance with clients, resulting from her own adverse childhood experience – yet this felt different to Gail as she became flooded with her body's physiological 'remembering'.

Our supervisory space allowed Gail to stay with the feelings she had while anticipating the arrival of the client, the emotional experience of being with her, and the ending of each session. When we explored this alongside trauma theories and transference, Gail felt encouraged to consider that the child's silence might not be resistance but a form of communication. Gail recalled that the referral had stated that the mother was insistent the child attend. We therefore questioned what might be unspeakable for the family and for what it was that the mother hoped the child might be a voice.

Following our discussion, Gail went back to the EWO, and, following further social services intervention, it became apparent that domestic violence was a feature of the family's experience – one that could not be spoken about by mother or child. Here, the key to understanding this child's world was in the supervisional processing of the resonance of what was unspeakable for her.

Alison Smyth is a counsellor and clinical supervisor in private practice in Northern Ireland.

NICK LUXMOORE

Considering... DEVELOPMENTAL PERSPECTIVES

Age matters. There's a developmental perspective on every young person's struggles. Yes, bad things will have happened in a young person's life, experiences that'll need to be talked about in order to make sense of that young person's (often unspoken) thoughts and feelings. But these bad experiences will always have been happening within a developmental context…

A bereaved 11 year old, for example, will also be about to start (or will have recently started) secondary school, and will be looking backwards and forwards with mixed feelings.

A bullying 12 year old will typically be starting to push the boundaries at home in a quest for greater independence. He or she will be busily trying out different roles in relation to friends and enemies. Sex will be in the air.

A 13 year old, furious with school, will be coming to talk about that fury at the same time as his or her relationships at home will be changing. Puberty will have kicked in. There'll be sexual curiosity and a preoccupation with agency: 'How much control do I have in my life? How much control do I want?'

A self-harming 14 year old will be trying to make sense of strong feelings about other people, just as the school is launching its rhetoric about exams. There'll be much talk of 'your future' and no talk of failure.

A 15 year old presenting with 'anxiety' will be carrying these residual issues and adding some more: 'What'll become of me? Will I ever be loved? Part of me wants to start all over again!'

And so it goes on, all through life. We're always at a 'stage' in our lives, characterised by certain developmental issues. Adolescence is a compression of stages.

Of course I'm generalising, simplifying. Of course there are exceptions to every developmental rule. Sometimes there are cultural expectations affecting a young person's development and, naturally, counsellors take these into account. But in my experience, it's always important to keep a broader developmental context in mind, because the young person's presenting issue – however urgent – is likely to be the tip of a developmental iceberg. Once the presenting issue has been explored, it's time to start exploring the iceberg lurking below the surface. Counsellors are forever trying to ease young people through developmental transitions, developmental stucknesses, offering relationships in which young people can start to explore a range of underlying issues at the same time as addressing all the bad stuff they originally came to talk about.

Nick Luxmoore's latest book, *Practical Supervision for Counsellors who Work with Young People* (Jessica Kingsley, 2017), is out now. www.nickluxmoore.com

The therapeutic relationship

Rebecca Kirkbride *continues her short series based on what we need to know, consider and draw on to be competent practitioners with adolescent clients, as indicated in BACP's* Competences for Humanistic Counselling with Young People (11–18 years)[1] *and her new book,* Counselling Young people: a practitioner manual[2]

According to the BACP competences for therapeutic work with young people,[1] 'the ability to foster and maintain a good therapeutic alliance' is a core competency for all of us. This reflects an idea now firmly at the root of therapeutic understanding: that the relationship between client and practitioner is at the heart of the therapeutic endeavour, and that the quality of this relationship is a key indicator for the success of therapy. However, this leaves us with the question of what is meant by the terms 'therapeutic alliance' and 'therapeutic relationship', and how we know when our practice is contributing positively to this and when it might be detracting.

Much of our current understanding of these terms comes from the work of psychologist and psychotherapist Edward Bordin.[3] He theorised that the alliance was made up of three interlocking components: the *bond* or attachment between therapist and client; agreement about the *task* in hand; and the *goal* or expectations, long and short term. He suggested that these components could be applied to all psychotherapeutic modalities. They may appear slightly differently, depending on the mode or type of therapy being practised, but having them in mind is certainly useful when we attempt to establish and maintain a therapeutic relationship.

Without the *bond* in place, therapy is unlikely to be successful. This raises the question of how a good therapeutic bond is developed, along with what needs to be considered in this respect in work with young people.

Carl Rogers had already been exploring the impact of the quality of the therapeutic bond on the progress of therapy, as part of the development of humanistic therapy. The BACP competences refer to his 'relationship' conditions, about which he wrote: 'If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur.'[4] How, then, do we go about providing this 'certain type' of relationship in which growth will occur?

For Rogers, this meant having the three 'therapist-offered' (or relationship) conditions of *empathy*, *genuineness*, and *unconditional positive regard* at the core of the endeavour. And there is now an increasing amount of empirical evidence for the effectiveness of these conditions. For example, in a review of existing research examining the therapist characteristics and techniques that positively have an impact on the therapeutic relationship, Ackerman and Hilsenroth[5] identified factors that are empirically associated with the formation of a positive working alliance, across a broad range of psychotherapy interventions. These have subsequently been integrated into the BACP competences framework (see box) and demonstrate the importance of warmth, acceptance, curiosity, empathy and honesty in *all* therapeutic work, including that with young people. In fact, for reasons I will explore in the rest of this article, it's even more important to be aware of these factors in our work with young people, to help overcome some of the givens that young people live with.

Factors associated with forming a positive therapeutic alliance[1]

- Being flexible and allowing the client to discuss issues that are important to them.
- Being respectful.
- Being warm, friendly and affirming.
- Being open.
- Being alert and active.
- Being able to show honesty through self-reflection.
- Being trustworthy.
- Being able to demonstrate an understanding of the client's perspective and their situation.

The given of adolescent development

We need to have a good sense of our client's developmental stage in order to assess how this might affect their capacity to establish and maintain a therapeutic relationship, as well as what might be required to help with this. Young people attending counselling are often somewhere in the process of separation and identity formation, and Anna Freud reminds us that forming a therapeutic alliance can be particularly difficult during adolescence when young people are attempting to separate from 'childhood objects', yet therapy 'promotes the revival of the infantile relationships in the transferences'.[6] She goes on to warn that 'this is felt as a special threat by the patient and frequently causes the abrupt ending of the treatment'.[6] In this respect, the formation of a therapeutic relationship, and its requirement that the client form a bond with an adult figure, is counter to one of the key developmental tasks of adolescence. So we must ensure that the therapeutic relationship is based firmly on the needs of the young person. What do *they* see as the problem/s they are struggling with? What would they like help with? Focusing on these client-centred questions and having them as the basis for the therapy enables the young person to develop a sense of trust that counselling offers a space that will facilitate their own self-discovery and understanding. It's also a way of modelling for the client something of what it means to be an adult and have agency and choice regarding their counselling.

Young people experiencing the trials of puberty and adolescence may naturally have a perspective on themselves and their world that appears strange or self-centred to the adults they meet in school or at home. Adolescents can sometimes feel at odds with the prevailing adult culture. In this respect, it's really important for young people to be offered acceptance and understanding by us as they find out about themselves. They sometimes experience adults as dismissive of their concerns, overanxious about their struggles, or punitive in their responses to their dilemmas or mistakes. When they come for counselling, it's therefore important to establish an understanding that here is an adult who is curious and interested in discovering more about them and their experiences, in order to help them find their own solutions.

The given of unavoidable inequality

When a young person comes for counselling, regardless of the age of the counsellor who sees them, the counsellor is likely to be viewed by the young person as an independent adult who has successfully managed the transition from childhood. This introduces an unavoidable inequality in the relationship from the start. Obviously, those of us who work with adults are subject to various projections and fantasies regarding how well we are able to manage the stresses and strains of adult life, but the difference is that we can still be considered a peer by those clients, whereas this is not the case with younger clients, who are still dependent, to some extent, on their parents/carers, or sometimes the state, for support. Again, it's important here that we assess to what degree our client has separated psychologically from their parents, no matter their chronological age or their physical separation.

The formation of a therapeutic relationship, and its requirement that the client form a bond with an adult figure, is counter to one of the key developmental tasks of adolescence

The given of being 'sent' for counselling

Another consideration is the possible impact on the relationship of the way the young person accesses counselling. As Campbell and Simmonds suggest: 'Fostering an alliance with children may be more difficult because children rarely refer themselves for treatment, can be reluctant to enter therapy, infrequently recognise the existence of problems or agree with adults on therapeutic goals.'[7] So it's vital that we take steps to find out what brought the young person to counselling; whether they have a clear sense of what they'd like to work on, or whether they're coming because of something their parents or teachers have an issue with. In this way, a therapeutic relationship can be established, based on the client's idea of what they would like to work on, taking into account the client's perspective and experience. As we saw earlier, Bordin[3] suggests we come to an agreement about the purpose and goals of therapy as this is a vital component of the therapeutic alliance. This can be challenging for counsellors in schools where the referral might be more about the needs of the school. Similarly, in private practice, parents often make the initial referral and support the therapy financially, and practitioners may feel under pressure to direct the client towards the issues the parents have suggested they need to work on, rather than those the client may be struggling with. A simple way of managing this is to be very clear from the outset of the work that this is a space where the client can bring anything that is bothering them, and that this will be the focus of the work.

Negative relational factors

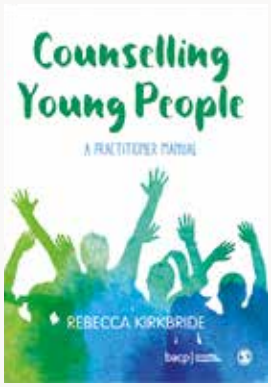
The BACP competences identify certain factors as reducing the probability of us forming a positive therapeutic alliance:

- Being rigid.
- Being critical.
- Making inappropriate self-disclosure.
- Being distant.
- Being aloof.
- Being distracted.
- Making inappropriate use of silence.

If we demonstrate these factors on a consistent basis, it is unlikely that any client will feel attended to and safe enough to explore their issues. But young clients, in particular, can find the use of silences anxiety provoking to a degree where it might become difficult for them to remain in therapy. This is not to say that counsellors need to be overactive in their sessions with young people, but rather to be mindful of how 'holding a silence' might be experienced by our client, particularly if they're feeling vulnerable – or if this is early in the relationship and before an alliance has been established. If we use silences in our work, it might be helpful to explain the rationale for this to the client at the outset, so that they understand what this is about in terms of the therapeutic process.

This also relates to Bordin's second point, concerning the task of therapy. It's important we don't assume that a young person automatically understands what counselling is, or what it entails. Young people are unlikely to have an understanding of different therapeutic modalities and may not be interested in the difference between, for example, humanistic and psychodynamic ways of working. What might be very helpful is that they understand what the rationale is for the therapy they are being offered, how it is intended to help, and what methods will be used to this effect. This attention to the therapeutic frame in the early stages of work is more likely to ensure that the client is an active participant and not a passive recipient of therapy. This is also likely to improve the quality of the therapeutic relationship and ultimately the outcome of the work.

The importance of establishing and maintaining the therapeutic relationship cannot be overstated. As Clarkson suggests, 'relationship or the interconnectedness between two people has been significant in all healing since the time of Hippocrates and Galen'[8] – something that is borne out every day in the practice of counselling and psychotherapy.



Book offer: Counselling Young People

There is an exclusive 25 per cent discount for readers of *BACP Children & Young People* when purchasing this book hot off the press in December – please input code UK17CYP at the checkout on SAGE's website. www.sagepub.co.uk

Rebecca Kirkbride is an author and senior accredited counsellor of adults and young people in private practice, as well as a clinical supervisor for other counsellors. She is author of two books: *Counselling Young People in Private Practice: a practical guide* (Karnac, 2015) and *Counselling Young People: a practitioner manual* (Sage/BACP, 2017), details of which can be found on her website. www.rebeccakirkbride.com

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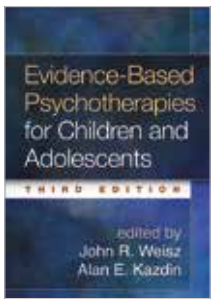
REVIEWS



Evidence-based psychotherapies for children and adolescents (3rd edition)

John R Weisz and Alan E Kazdin (eds)
Guilford 2017
ISBN 978-1462522699 £55.99

I can't imagine anyone reading this book in one fell swoop. It's a book to dip in and out of. It should certainly be in libraries as a reference, but you may think it's worth the investment, even at £56, to have such an erudite and hugely practical reference book on your shelf.

The editors' focus is on any mode of psychotherapy found to work with the problems children and young people face. How to arrive at what works, they argue, can be tricky because 'with many different parties, criteria for treatment selection, and resources that enumerate and review treatments, there is no single consensus of [evidence-based psychotherapies] EBPs'. So they have taken a pragmatic approach and chosen interventions and programmes of research with an empirical evidence base, and those they felt 'would be exemplary and in which palpable progress has been made in controlled studies'.

This resource is aimed squarely at clinicians and researchers. For clinicians, it includes comprehensive information on the clinical problem, the model, the rationale for treatment, description of the treatment, and information on the treatment manuals used. For researchers, it details outcomes of treatment and questions still to be researched. It includes both internalising and externalising disorders and problems, as well as best practice for working with self-harm and suicide, trauma, autism, eating disorders, enuresis and encopresis, and substance use.

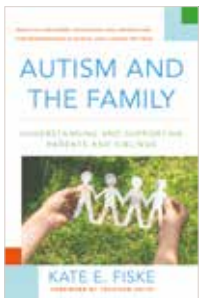
A good example of the approach is in the chapter on 'Copy Cat' – a child-focused CBT treatment for anxiety. There is a clear explanation of the conceptual model underpinning the treatment: 'Anxiety is conceptualised as tripartite, involving psychological, cognitive and behavioural components,' and what actually happens during treatment: 'Relaxation is practised via coping modelling and role play. The therapist describes anxiety-provoking scenarios, and models recognition of anxious feelings and accompanying somatic responses. The therapist demonstrates coping by taking deep breaths and relaxing muscles, describing what is being done step by step.'

Included is the evidence on outcomes and modifications to this treatment – for example, when it is more effective to work with the individual and when to include the parent(s)/carer(s). It concludes with a discussion on the next directions for research.

The second half of the work has a different emphasis. It looks at implementation and dissemination of treatment with new populations and settings, and critical issues for the field. There are some really interesting chapters here, covering a wide range of topics from EBPs with ethnic minority children and adolescents, and the development of Children and Young People's IAPT. Many of the chapters in this section will challenge you to review your current practice. The chapter 'Assessment Issues in Child and Adolescent Psychotherapy' made me rethink the way I interpret multi-information, multimethod outcome measures. 'In other words, pretend your battery is more like a single measure of treatment outcomes, and each measure in your battery is an "item" on this measure. If prior work indicates that each of these items "behaves" differently in estimating change, shouldn't you capitalise on this diversity in estimates of change, rather than erroneously assume that each item should "hang together" like items on a unidimensional measure?'

To conclude, this is an excellent reference work, suitable for both trainees and experienced clinicians. It is also a challenging read that will encourage you to consider whether, based on the current evidence, you are doing the best for your young clients. Encouraging this level of reflection can only be good for our profession.

Linda Bean MBACP (Accred) works as a psychotherapist/supervisor in the NHS and in private practice. LBCounsellor@sky.com



Autism and the family: understanding and supporting parents and siblings

Kate E Fiske
Norton 2017
ISBN 978-0393710557 £27.50

I was looking forward to reading Fiske's book, which promises to provide 'ready-to-implement resources and approaches for professionals in school and clinical settings'. As a professional working in schools that seem to have ever-growing numbers of children and young people being assessed for autism (and with a member of my own family recently diagnosed with ASD), I was hoping for some tips for supporting the families I meet.

Fiske's book provides just that. This is a kind of best-practice compilation collated from the author's own clinical experience, and from interviews with families where a child is affected by autism. Chapters cover issues such as the experience of diagnosis; the effects of a child's autism on parents, parental relationships, and siblings; supporting parents to seek and implement appropriate interventions; and involving the wider family system in a child's care. There is a bulleted list of 'clinical takeaways' at the end of each chapter, and a long list of books and online resources at the back.

All this material is potentially helpful, but unfortunately I found it really hard to stay engaged with the book for its 300+ pages, mainly because of the tone. I respond best to curiosity and collaborative enquiry, and Fiske's writing is very much in the style of 'I am an expert and thou shalt…' – with 'professionals should…' and 'practitioners must…' peppered liberally throughout.

In fairness, the book isn't really aimed at me. Fiske is working in the US. In a theoretical text, this probably wouldn't be an issue, but context is important when a book is offering practical advice. For example, in a chapter on the family's experience of diagnosis, Fiske states: 'Immediately after diagnosis, many more professionals will begin to work with the family as ASD-specific treatments are identified and initiated with the child.' But I'm not sure this holds true in the UK; most of the autistic children I know are in mainstream education and generally don't receive much additional input following diagnosis. Certainly the costs of private treatments, or the perils of selecting the right behaviour analyst, are not the kinds of issues that the parents I meet are typically concerned about.

Aside from cultural differences, I wonder whether this book would work better for professionals whose specialties *don't* foreground feelings as a matter of course. Perhaps for colleagues whose roles usually involve dealing with practicalities, lists of symptoms, or behavioural checklists, a reminder to take time to really hear from family members is just what is needed to make their 'autism journey' more human and hospitable. But counsellors have empathic listening to lived experience at the heart of their practice: advice about the rudiments of actually hearing what someone is telling us (rather than making assumptions and jumping in with practical advice) is probably redundant. Not a book for me, in short, but perhaps something to leave on the help-yourself bookshelf at work.

Sarah Haywood is an art psychotherapist, supervisor and trainer working in Edinburgh.

Benny's hat

Juliet Clare Bell
Pomelo Pip 2017
ISBN 978-1999729608 £7.99

The duo producing this beautifully illustrated book (the illustrator is Dave Gray) have 'form' from their previous book, *The Unstoppable Maggie McGee*, published by Birmingham Children's Hospital in 2015. They have now created Pomelo Pip to publish further stories that they describe as 'beautiful fictional picture books dealing with complex and distressing childhood issues that are often underrepresented in mainstream fiction'. For both books, they worked with families and young patients to make the stories as authentic and respectful as possible. Bell herself is a former research developmental psychologist.

Benny's Hat is about childhood bereavement – specifically sibling bereavement – and £2 from every sale goes to Edward's Trust, supporting children and families during serious illness and bereavement. But the question for counsellors and therapists is: will this book help me in my work with children?

Told in the present tense by this experienced children's writer, the words-to-image ratio is spot on – sufficient to read with someone, but engaging the listener via the image, with its extra information, as much as via the narrative. In a counselling session, this would be perfect for promoting discussion about the little girl, Friz (who tells the story), and her family as they experience the illness

and death of her big brother Benny, who loved his hat. The hat also plays a significant role in the story, and besides being a unifying motif narratively, it allows the child to possibly discover and talk more about particular, familiar, funny, meaningful aspects of the sibling they themselves have lost. We witness how both the illness itself and the realisation that Benny will die affect the family members. We witness changing emotions – and how Friz's are expressed differently from those of her parents. We also witness some tiny, poignant but satisfying elements of starting to come to terms with the loss.

There is enough in the actual story for the experienced therapist to use flexibly in any way the child leads. But for less experienced counsellors, there is also a spread at the back of the book, intended for parents, suggesting conversational openers that are based on specific parts of the story (written by a bereavement counsellor), plus some suggested activities that might help parents with their child if another of their children is terminally ill. Some familiar organisations are then listed, although I had not heard of Together for Short Lives (www.togetherforshortlives.org.uk).

This story addresses the issues in a sensitive way and the illustrations are large on the page and draw the reader and listener in. It would earn its place in any therapy room where primary school children come, but possibly not pre-school children, although I haven't had a chance to try that out and I may be wrong. Schools might benefit too from having a copy available in the library or via the SENCO.

Eleanor Patrick is editor of this journal.

Creative ways to help children manage big feelings

Fiona Zandt and Suzanne Barrett
Jessica Kingsley 2017
ISBN 978-1785920245 £19.99

Subtitled *A therapist's guide to working with preschool and primary children*, this is a very helpful book. Reading it from cover to cover would be good for engaging in a piece of personal, professional development at home that will hone your skills and remind you of the basic competencies in working with children. The book is well organised and suitable for both experienced and newly qualified clinicians. It is based on the combined clinical experience of the writers: Fiona Zandt, who is a clinical psychologist working in Melbourne, and Suzanne Barrett, who is a clinical psychologist working privately with children and families.

The brightly coloured, glossy manual includes a broad range of creative ideas and activities and provides a playful therapeutic approach to help children and families – but it will particularly help children to identify and communicate difficult feelings and develop coping strategies for the challenges of life. Remember those days when you are anxious about how to keep a child engaged in their sessions? This is the go-to book to grab off the shelf.

The authors spell out key areas for competence, such as in Chapter 2, which looks at 'The Importance of Assessment' and offers a very readable plan for assessing children. Secondly, it underlines the importance of developmental considerations when working with children. A chapter called 'Key Approaches' offers a journey through ways of working with children, which is informative and encourages further reading.

The approach is strongly influenced by CBT with children, but is essentially eclectic, drawing on a number of schools of thought that include concepts from acceptance and commitment therapy (ACT), narrative therapy, systemic family therapy and cognitive behavioural play therapy (CBPT). The first part of the book outlines the general approach and gives an excellent review of the principles of working therapeutically with children. The second half presents the activities, and these are coherently presented. A handful of the activities will be old favourites, such as 'Body Mapping', 'The Calm Box' and 'Feelings Thermometer', but there are novel games there too, some of which I will definitely use, such as 'Feelings in my Family', which includes winding a ball of wool round family members to show how their feelings and behaviours affect one another – and culminates with cutting them out with scissors if there are any knots. There are 47 activities in all, which should cover all bases in the therapy room.

At first I thought 'not another manual telling me what to do in my therapy room', but even a superficial first read showed that this is really intended to give you fresh ideas and approaches that are skilfully thought out and have been put to the test. I would definitely recommend it to be placed on the bookshelf in the therapy room for those days when you need inspiration.

Jo North MBACP (Snr Accred) is a psychotherapist working with children, adults and families.

The developmental science of early childhood

Claudia M Gold
Norton 2017
ISBN 978-0393709629 £22

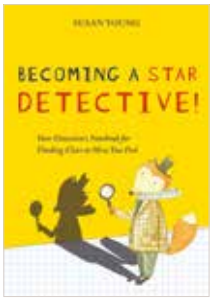
Subtitled *Clinical applications of infant mental health concepts from infancy through adolescence*, this book presents the latest research from developmental psychology, genetics and neuroscience, and demonstrates how it is applied to common childhood problems, from attention deficits to anxiety and sleep disorders. Gold is a paediatrician who has practised general and behavioural paediatrics for 25 years in the US, and currently specialises in childhood mental health. She demonstrates the importance of working with parents when treating difficulties in infants, children or adolescents, and shows the relevance of taking early, textured, developmental histories, listening for multigenerational loss and trauma, and providing time and space for parents to tell their stories, so that relationships are able to heal and mutual regulation can be restored. The book is split into two sections. The first provides an overview of the key concepts within infant mental health, including the latest research within attachment theory, epigenetics and the role of stress-response systems. The second shows how these concepts can be applied in clinical work – addressing specific topics such as postpartum depression, anxiety or explosive behaviour. Although the book is focused on infant mental health, it also demonstrates how the same concepts are important within adolescent work or even work with adults.

The book's strength is its accessibility for a wide readership. It is particularly helpful for child therapists, who will regularly encounter many of the examples that Gold uses. However, it could also be used by any professional working with children, or by therapists working with adults, where an increased knowledge of the concepts can increase understanding of their client. Although written for practitioners, the book could also be used to increase parents' understanding of their child. Another strength is Gold's ability to comprehensively describe scientific concepts, while continually linking them to their practical application and relevancy in our work and society. I have found myself viewing client situations through this framework without difficulty.

This has also caused me to rethink my own practice as a school counsellor and consider whether it might be more effective to engage and involve parents more in my practice. Although Gold's method as a paediatrician does rely on the engagement of parents, she shows how practitioners might do this, and how this can go beyond simply providing parents with more strategies or advice. I am now using the opportunities I have with parents in a different way to previously. Instead of feeling I need to provide advice, I find myself more able to listen curiously and use the meeting to increase our understanding of what might be happening for the child and family. I am looking forward to seeing how this develops in my practice.

I find it difficult to find any weaknesses in the book and I would recommend it to any practitioners working with children or adults. Even if you don't have the same opportunities to work alongside parents, or even work with children at all, I believe it can still be of benefit in understanding clients better from a scientifically informed framework.

Sarah Burrell
School counsellor



The STAR detective facilitator manual and workbook

Susan Young
Jessica Kingsley 2017
ISBN 978-1785921681 £24.99
ISBN 978-1785921803 £8.99

When I first saw this book, I was pleased the author was based in the UK. So much literature originates in the US and is often not as relevant to our work here because our thinking is often very different. Imagine my dismay, therefore, when I discovered that the language, spelling and even the illustrations are aligned more with American culture.

The programme is aimed at children who have been diagnosed with attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), attention deficit disorder (ADD) or other behavioural problems, and is purely a behaviour modification programme. Initially, I was pleased to see that there was a systemic element to the work – until I discovered that parents/carers are engaged as 'coach' to the child to ensure that they continue with the work between group sessions. This would be difficult to imagine with some of the parents I work with, who themselves present with emotional and behavioural difficulties.

As a programme that teaches children how to challenge their thinking and modify their behaviour, it appears to be well thought out and the instructions are clear to follow. The suggestion is that each child is given the *Becoming a STAR*

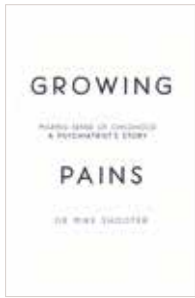
Detective! workbook, but I don't think many eight to 12 year olds are likely to engage in a black-and-white book of worksheets that also contains the 'coach' training sessions and coach guide. Maybe the intention is that the worksheets are reproduced, yet on the back cover it suggests: 'To be given to any child upon joining the STAR program…' At almost £10 each, it would make for an expensive group.

Having said that, the programme is very clearly described and easy to follow in a session-by-session description. There is a claim that facilitator training for this programme is available. But when I checked out the given website, I could not find any training on offer for this particular programme. However, they do offer 'boot camps' for various ages of children. Really – boot camps!

There are also online resources linked to the programme – a series of PowerPoint slides for each session, which are clear and uncluttered but not particularly inspiring. I'm not sure what value they would add to a session with children.

What, for me, is really missing from this whole programme is any sense that children who have behavioural problems might need some kind of therapeutic engagement – with them individually, and with the other members of their families, to discover the aetiology of their distress. So – this is not a programme that offers a therapeutic way of working with distressed children, but, as one of the reviews states inside the front cover, it is 'a theoretically sound, evidence-based, manualised, cognitive behavioural program that will enable children to enjoy learning social, cognitive, emotional and behavioural skills and values essential to their development of pro-social competence'.

Lynn Martin is a certified integrative psychotherapy trainer/supervisor and a certified transactional analysis psychotherapist working in private practice in Devon.



Growing pains

Mike Shooter
Hodder & Stoughton 2018
ISBN 978-1473643246 £18.99

Growing Pains reads like a compelling novel with complex characters and challenging plots. The difference is that each chapter explicitly articulates the voices of one or two children, young people or families who the author has worked with sometime during his 40 years.

Mike Shooter, the author (and who is also immediate Past President of BACP), is a passionate believer in the power of stories – actively listening to and creatively telling them. He also believes in sharing his own with great honesty.

Shooter's personal story includes debilitating depression while studying medicine and managing a young family. Fortunately for him, he received support and understanding and was able to return to his studies. Fortunately for his hundreds of patients, he became a psychiatrist, a deeply empathic, personable psychiatrist. He has allowed the lessons of his experience with depression, and with what led him to his crisis, to infiltrate every interaction he has had since then with vulnerable, needy CYP and adults. His capacity to listen and learn from each individual – whatever their background and life experience – is integral to his being, like a thread of his DNA that weaves through all 25 chapters.

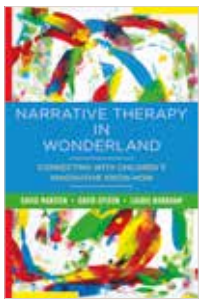
Growing Pains is divided into three sections: like the structure of a therapeutic relationship, there is a beginning, middle and end. Firstly, we read about Shooter's guiding principles: self-awareness, the importance of the relationship, and patient empowerment. With that groundwork established, the middle chapters address the prolific issues that Shooter's patients have brought to him. Some, if not all, will be issues we are likely to meet in our own practices: 'The development of trust; the question of identity; how to communicate with little children; what adolescence is all about; the traps in which children may find themselves, in personality labels, family dynamics and culture; the handling of risk and its relationship to the law and to emergencies; peer group and social pressures; violence and stigma; and the varieties of approach.'

Shooter ends the stories with chapters on the pain of loss and separation, be it in family relationships or the ending of therapy. Within the bleakness of the family stories he tells, his inspiring approach to life and relationships continues to speak. As Shooter began, so he finishes: by expressing opportunities for growth and change in stories in which optimism seems only thinly available. Not all his stories are 'happy ever afters'. Some are brutal. Yet even within the brutality, Shooter's optimism still quivers with life: change is possible. There is always hope.

Growing Pains is inspiring. Repeatedly, Shooter had me thinking: might I have responded differently to the child, to the young person, to the family with whom I had worked if I had read this before meeting that child or young person or family. Or: if I'm able to propagate the deep wisdom and compassion that has grown in Shooter, might my work with children and young people be different, better?

Growing Pains is a book I look forward to re-reading. I highly recommend it to counsellors and trainees alike. It will be one of only a few that live on the shelf above my desk for easy reference.

Augene Nanning is Manager of Caris Islington Bereavement Service, with a private supervision and counselling practice in North London. info@augenenanning.co.uk



Narrative therapy in wonderland

David Marsten, David Epston, Laurie Markham
Norton 2016
ISBN 978-0393708745 £28

Subtitled *Connecting with children's imaginative know-how*, this book offers an alternative to therapeutic perspectives that treat children as vulnerable and helpless. It invites readers to consider how the imaginative gifts and knowledge of children, when supported by the therapist and family, can bring about dramatic change.

The book has three well-qualified authors, two from Los Angeles and one from Auckland, New Zealand. They divide their the book into 11 chapters, plus an introduction and epilogue. Each chapter has subheadings and a conclusion, with beautifully narrated vignettes from clinical practice woven throughout. It gives a real sense of being written by therapists for therapists, and I found within it some very practical inspiration. For example, 'The Wonderfulness Interview' and 'Outsmarting the Problem by Mischievous Means'.

The authors draw from what may well be familiar stories in the reader's own childhood to illustrate the subjects covered within the chapters, such as *Alice in Wonderland* and *Peter Pan* – both of whom travel between the real and the imaginary effortlessly. Placing the child as protagonist in the story of their life, rather than as a passenger within the family, gives rise to a whole new world of intention, participation and decision making in the unfolding drama of their lives.

The authors believe that emotions and labels given to children by adults can be held externally as characters by the child, which allows them multiple expressions of identity. Therapists and parents are encouraged to ask a different kind of question. Instead of 'Are you sad?', ask 'How does Sadness find its way in?' Therefore, instead of talking to a sad child, we would be talking to a child about sadness.

This book explores the extraordinary fact that children and young people are far better equipped, through their imaginative know-how, to take on life's challenges than the adults in their families realise. It is the enlisting of help from loved ones and imaginary friends, coupled with mystery and wonder, that holds the greatest potential for transforming a problem into an opportunity. Although the three authors live in different continents, there is a synchronicity in their writing. They clearly have a universal model used in their individual practices that can in turn be adopted by other practitioners working in other parts of the world. They demonstrate through well-written and engaging case studies how they use the model, its effectiveness and how it can be adapted to any circumstance a child may be facing. In particular, how children and young people can defeat emotional characters, such as Temper, Meanness, Anger and Killjoy, when these destructive figures move into a child's life.

This is a book packed with expertise, wisdom and interventions, and I thoroughly recommend it.

Rachel Eastop MBACP (Accred)

The rage for life

David Taransaud
Chaigeley School 2016
Available from www.chaigeley.org.uk
£9.95

The purpose of this wordless, black-and-white story book (so writes the author in the accompanying resource guide) is to help adults connect with young people through the safety of the metaphor. I've enjoyed Taransaud's previous books, which portray his therapeutic work with angry, aggressive, hard-to-reach adolescents.

The book does, in fact, begin with words. It states that Lou, the book's protagonist, is a boy in wolf's clothing and that he is 'wild inside'. The reason for this we are yet to discover; perhaps he was born this way or maybe the beast was 'beaten into him'. This is a question often posed about angry and aggressive boys, particularly those who have witnessed violence at home.

The book is divided into three parts of a dozen or so pages, depicting events along a timeline. In Part 1 (8.34pm), Lou is at home with his anxious-looking mother as they await the arrival of a menacing, bottle-swigging figure, presumably the dad. Scenes of domestic abuse are portrayed, prompting Lou to unleash the multi-headed wolf that rises up and escapes. I was confused by the wolf's subsequent attack on a frightened homeless man. I'm guessing this portrays an act of displacement as Lou projects the rage about his father onto someone more vulnerable. We are supposed to be working in the metaphor, so this is open to interpretation.

In Part 2 (10.58pm), someone calls 999. Father is handcuffed and removed while mother is stretchered away to safety. I had a 'yeah right' moment, as this depicts a fantasy scenario for many families. In reality, it takes months or years to acknowledge the need for help, and even longer for that help to arrive. It's unclear what happens to Lou at this point in the story (is he left alone? Is he taken away?), but images follow of the 'beast on the loose'. The wolf is depicted facing riot police and attacking domestic animals. I understood this as Lou once again taking on the role of aggressor as a defence against his own vulnerability.

Part 3 (6.15am), sees the arrival of a new figure, a blind man who, to me, resembled Clark Kent. This superhero (my interpretation) meets the wolf in a dark alley, but rather than be afraid, he offers a hand of kindness, presumably because he can't see the beast. Lou, the boy, reappears and the wolf is released.

The images are powerful but, for me, juvenile. The book's target audience is challenging, aggressive teenagers – the author states his intention to fill a gap in the storybook market that is mostly aimed at children. I don't think he achieves that. The boy, Lou, looks about six or seven years old. He is drawn on the cover wearing striped pyjamas and holding a teddy bear. Thinking in the metaphor, I can see that this little boy, surrounded by the shadow of a wolf, could portray the frightened child within the aggressive adolescent. However, I can't imagine the target audience taking the trouble to work that out.

I've put this book on my shelf and will introduce it to some of the younger young people I work with. I'm interested to discover how they respond to and interpret it and whether they are able to use it as a metaphorical tool to explore their own experiences. I think for younger children it could be a valuable resource. For adolescents, probably not so much.

Jeanine Connor MBACP

Robin and the white rabbit

Emma Lindström and Åse Brunnström
Jessica Kingsley 2017
ISBN 978-1785922909 £9.99

A glossy hardback, this book is aimed at helping children with autism to look at ways to communicate and join in with other children. The book also demonstrates different ways in which parents and school staff can help children to express their emotions. The story is short and easy to comprehend and is aimed at four to 10 year olds.

There are two authors, one a pre-school teacher who works with children who have special needs, and the second a Master of Education in arts and design. The book is therefore well illustrated, with simple drawings that clearly conjure up an image of what is happening in the storyline.

The story centres around a white rabbit who helps a young autistic boy to discover a way to communicate his feelings. The white rabbit uses visual cards and asks the boy simple questions. Gradually, the boy is able to tell the rabbit how he is feeling by visualising his emotions using the cards. The boy is then able to make a start on knowing his peers – by noticing that one of them is waving to him. He feels able to wave back. By understanding that there are many ways in which to communicate, not just verbally, children with autism will learn to feel less isolated from their peers.

In my opinion, the book uses a simple way to show children, parents and school staff how to engage with children who have an autism spectrum disorder, and helps in overcoming some of the barriers to communication. The story also offers a tool for children who have autism to use in playground situations with friends, so that they can feel more confident in joining in. The simplicity of the wording and illustrations make the book inviting, and the use of the white rabbit makes it an enchanting story.

I think that this is a good buy for school libraries' SEND section and for parents to read with their children.

Julie Griffin works with young people in Lincolnshire, Leicester and Rutland in a variety of contexts.

FROM THE CHAIR

As normal on a Friday night, I closed up my office, made sure the alarm had been set and went to the car. As it was the weekend, I wasn't heading straight home but going shopping, followed by a meal with a friend. This was the first weekend I had no BACP or other counselling commitments. The weekend before, I had attended the Private Practice division's conference in London, with its theme of 'Identity: can you tell me who I am?' A thought-provoking day with people sharing at times very personal insights.

One of the main speakers was Shelley Bridgman, an award-winning, stand-up comic, who is now a leading psychotherapist in the gender dysphoria field. Shelley shared with us her journey towards discovering her identity and being able to tell others who she really is. It was a privilege and pleasure to talk with her and learn more about her.

Over the last few weeks I have also facilitated a 'Working with Children and Young People' day in Belfast. So It was good to be free from my volunteer commitments. I had been looking forward to having this free weekend and attending a family get-together, both to celebrate a 50th birthday and to welcome some Australian relatives who were visiting the UK.

The theme of that private practice conference was to come to the fore during the weekend – because this was no ordinary visit. My cousin had brought with him the ashes of his mother, my aunt Meta. Like many of their generation, Aunt Meta, together with her husband and young children, had emigrated by ship to the other side of the world. And her dying wish was to have her ashes buried in her parents' grave beside her sister (my mother).

We talked a lot over that weekend about our loved ones, about how much had changed, and about the colourful village characters who, once met, were never forgotten. For my aunt Meta, her identity was complete when she came back to this small place to be, in her death, with her loved ones. And, as so often happens at these times of get-together, the conversation came back to how proud various relatives would be of us today, if they were still here to see the pathways we'd all chosen. Although all but one of my mother's family had emigrated in the 1960s, a big part of their identity remained – as with my aunt – back home in the land of their birth.

My being a member of the BACP CYP Executive and part of the wider BACP family (as six-year-old Lexi would put it) for 'ever and ever', makes BACP part of my identity. My service with BACP has involved being a member, Deputy Chair and now Chair of the BACP Children & Young People division. Wendy Brown (Deputy Chair) has been a great support as we have led the CYP division forward together. Both of us are now moving towards the end of our time as 'office-bearers' in the CYP division. So plans are underway for the CYP Executive to appoint from within the group a new Chair and Deputy Chair, and the next journal will probably be my last as Chair.

Looking to the future, here is a note for your diaries: we will be holding our next CYP conference on **Saturday 24 February 2018**.

By the way, we had a great family get-together with the Aussie cousins, who were part of three generations of the family gathered that night who shared stories and sang songs.

Cathy Bell

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