

How to work therapeutically
with children and adolescents

By

Karen F Burke MSc

For

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Foreword

Bob Cooke of the Manchester Institute of Psychotherapy asked me to write this e-book on how to work therapeutically with children and adolescents when we were considering the Child Therapy World website. (www.childtherapyworld.com)

Bob, as a 'blue sky' thinker, envisaged a site where both clients and practitioners could access information, consider practice and a community could come together, who had an interest in, or practised working with children and adolescents.

I have, for many years, worked with children and adolescents therapeutically, both in agency settings and in private practice. I have worked in an adolescent referral unit and trained as an attachment therapist at a different agency. I was one of the initial facilitators/writers of the SafeBase Course © that is now a nationwide (UK) training workshop for adoptive parents of children who are displaying attachments traits or styles. I have enjoyed working with children and adolescents and I have continued to train, (when do we stop learning?), with The Theraplay Institute © of Illinois and am currently, (December 2011) working towards my next qualification.

What does this mean to me as a practitioner? Well, as well as years of experience, I bring a wealth of theoretical knowledge with me into the therapy room and it is this and the practice that I wish to share with you. As a Gestalt Practitioner I initially used the Gestalt model. As I found out more and worked more I saw other models and began to work with their tools and techniques. When I trained as an attachment therapist, again, I became more knowledgeable with another modality. Now, as I study the Theraplay © model, I have further equipment to use within my work.

As an individual I cannot possibly discuss all models and theories within this short e-book. However I hope that some of what I have learnt and am sharing with you, is of value for you and your clients within this area of work.

Thank you Bob, for giving me this opportunity to write and special thanks to Bruce, for his tireless support and for not complaining about editing my work,

Karen F Burke
Rossendale, UK 2011

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Chapter One

Child Development

For simplicity, except for the chapters that are specifically for adolescents, when I refer to 'children'/'child', I can be referring to either gender, between the ages of four to 18 years of age. I will also use the term, 'parents' and know that there maybe a single parent, or the parents could be a same sex couple.

One of the first things I believe that as practitioners we need to consider, is the child's developmental age. This can be quite different from the actual age the child is. I would suggest that you think about which developmental model you wish you use, and then think about which, if any, developmental milestone (s) is/are missing, or where there has been an interruption at. This will enable you to begin to plan your work. (See Chapter 3)

I use various models that allow me to make a preparation and a treatment plan to work towards. This initial planning can be of value at later stages to refer to when other issues may arise during the therapy, to ensure that the initial behaviours or traits are addressed to complete the work.

The Gestalt Model.

This is not particular to children; it is used for adults too by Gestalt practitioners and is valuable to see how children stop themselves having a full and contact-full life. This model looks at interruptions to completing a 'gestalt' and this can be applied to a certain situation or indeed to consider the child's (or adult's) way of being.

In a healthy way of being, a child can progress through each stage of the gestalt moving through gracefully and elegantly so there are no interruptions to full and final contact. However, there are some interruptions that can occur at *any* phase, therefore halting or skewing the gestalt, leaving either incomplete or interrupted situations. The Gestalt Therapy names of these interruptions are shown in diagrammatical form in Diagram 1. Clarkson, (1999, p 51-57)

Desensitisation – Minimising sensations

Deflection – Avoiding sensation or meaningful contact

Introjection – Being ruled by internalised 'shoulds'

Projection – Seeing in others, what I don't acknowledge in myself

Retroflection – Doing to my self, instead of to the other

Egotism – Blocking spontaneity by control

Confluence – Dysfunctional closeness

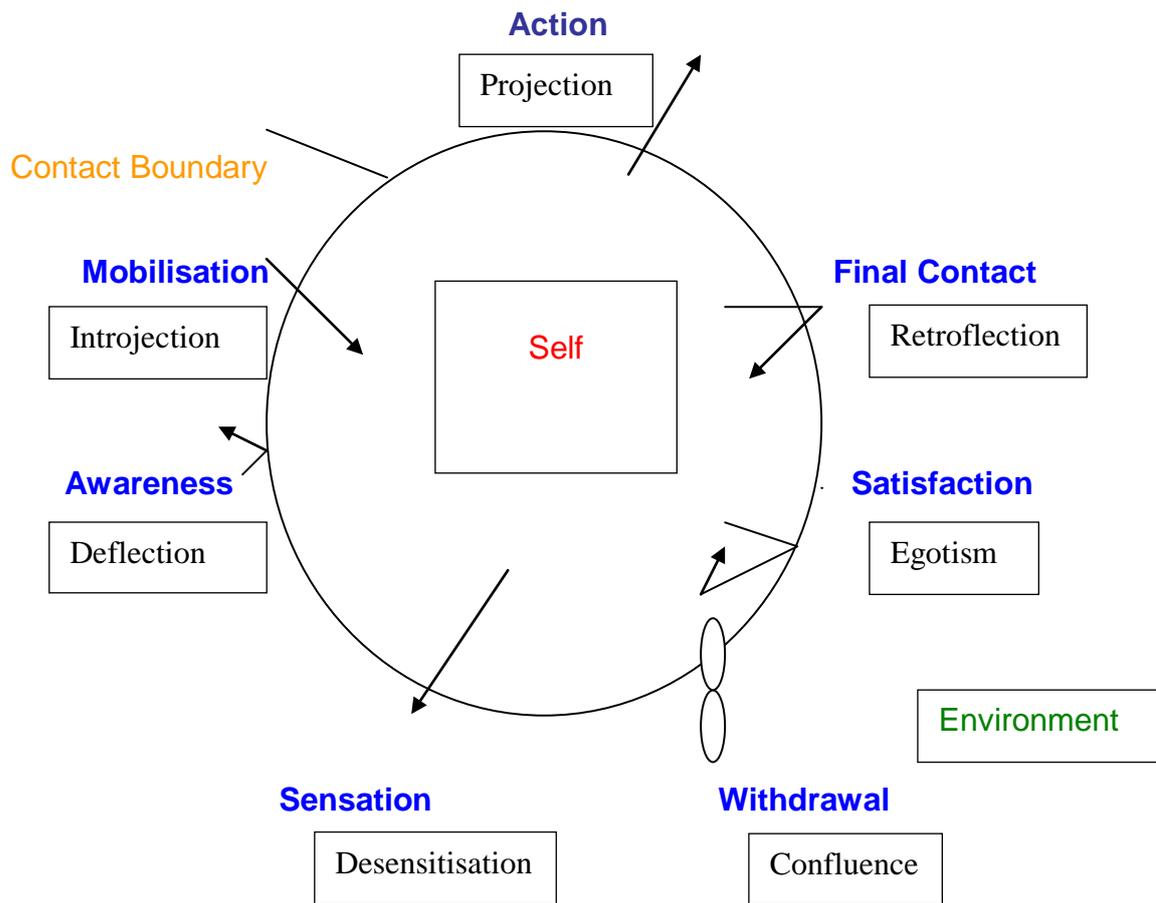


Figure 1. 'Cycle of Gestalt formation and destruction with diagrammatic examples of boundary disturbances at each stage', Clarkson, (1999,p56)

Erikson

| Stage | Basic Conflict | Important Events | Outcome |
|--|------------------------------|----------------------|---|
| Infancy (birth to 18 months) | Trust vs. Mistrust | Feeding | Children develop a sense of trust when caregivers provide reliability, care, and affection. A lack of this will lead to mistrust. |
| Early Childhood (2 to 3 years) | Autonomy vs. Shame and Doubt | Toilet Training | Children need to develop a sense of personal control over physical skills and a sense of independence. Success leads to feelings of autonomy, failure results in feelings of shame and doubt. |
| Preschool (3 to 5 years) | Initiative vs. Guilt | Exploration | Children need to begin asserting control and power over the environment. Success in this stage leads to a sense of purpose. Children who try to exert too much power experience disapproval, resulting in a sense of guilt. |
| School Age (6 to 11 years) | Industry vs. Inferiority | School | Children need to cope with new social and academic demands. Success leads to a sense of competence, while failure results in feelings of inferiority. |
| Adolescence (12 to 18 years) | Identity vs. Role Confusion | Social Relationships | Teens need to develop a sense of self and personal identity. Success leads to an ability to stay true to your self, while failure leads to role confusion and a weak sense of self. |
| Young Adulthood (19 to 40 years) | Intimacy vs. Isolation | Relationships | Young adults need to form intimate, loving relationships with other people. Success leads to strong relationships, while failure results in loneliness and isolation. |
| Middle Adulthood (40 to 65 years) | Generativity vs. Stagnation | Work and Parenthood | Adults need to create or nurture things that will outlast them, often by having children or creating a positive change that benefits other people. Success leads to feelings of usefulness and accomplishment, while failure results in shallow involvement in the world. |
| Maturity (65 to death) | Ego Integrity vs. Despair | Reflection on Life | Older adults need to look back on life and feel a sense of fulfilment. Success at this stage leads to feelings of wisdom, while failure results in regret, bitterness, and despair. |

Erik Erikson's theory is well known and it addresses the development throughout a life span. Erikson purports that at each stage a conflict is the turning point and when the conflict is resolved the person can then move onto the next developmental stage.

Freud

Freud, who was the first to consider development believed that the child's personality was fixed by approximately five years of age. He said that this personality was developed by 'libido', the psychosexual energy driving the behaviours, and the 'id' focusing on erogenous areas. Freud believed that if the stages are completed a healthy personality is the result. If this does not happen then the person will get 'stuck' at that developmental stage.

The stages Freud describes are

| STAGE | AGE | EROGENOUS ZONE | EVENTS | OUTCOME IF NOT MET |
|---------------|-------------------|--------------------------|--|--|
| Oral Stage | Birth – 1Year | Mouth | Feeding – trust they will be fed | Fixation on eating, smoking, drinking, over dependant upon others |
| Anal Stage | 1 – 3 years | Bowel and Bladder | Conflict re toilet training and control over bodily functions. | If met child feels accomplished and capable. If not, either a messy, wasteful life (anal – expulsive) or a rigid, over orderly life (anal retentive) |
| Phallic Stage | 3 – 6 Years | Genitals | Jealousy (Oedipus Complex) Difference between sexes | Boys may see their father's as rivals for their mother's affection and girls for their father's. (Electra's complex) Fear of punishment (castration theory) |
| Latent | 6 years - puberty | Inactive sexual feelings | The 'ego' and the 'superego' are developed and children are interested in hobbies and peers. | Sexual energies are directed to relationships and intellectual pursuits If this does not happen the child will not develop social skills or self confidence |
| Genital Stage | Puberty – Death | Genitals | Mature sexual interests and well balanced life style | Unable to manage a balanced life style |

Piaget

Piaget introduces that consciousness has four phases, each informing the other until each is integrated. He saw these as different periods of intellectual and moral reasoning – sensorimotor, before the age of two, pre-operational, from the age of 2 until 7, operational at 7 to 12 years of age and finally the formal between the ages of 12 and 18.

| Cognitive Stage of Development | Key Feature | Research Study |
|-------------------------------------|--|------------------------|
| Sensorimotor 0 – 2 yrs. | Object Permanence | Blanket & Ball Study |
| Preoperational 2 – 7 yrs. | Egocentrism | Three Mountains |
| Concrete Operational 7 – 11 yrs. | Conservation | Conservation of Number |
| Formal Operational 11yrs + | Manipulate ideas in head, e.g. Abstract Reasoning | Pendulum Task |

Daniel N Stern

Stern's theory, (1985), is that a series of stages which are mutually supporting and overlapping, the sense of the 'emergent self' forms between birth and two months. Later between two and six months a sense of core sense is experienced. The next period is when a core sense with another is recognised, followed between seven and fifteen months when a subjective self is formed and then later a verbal self during the second year of life and followed by the final stage of narrative self or selves. It is here at the age of four or older that the child can relate 'stories' where psychological explanations are implanted within the story and the child's identity is formed. Of course the child may choose at this age to distort reality too, as any parent knows.

The theories described here are just an overview of the many that are available to practitioners and each has their positive aspects. Each therapist will need to know their own theory in great detail to be able to understand and use them to assess each client.

Chapter Two

Assessment Sessions.

This is a time of reflection for you to decide if you are competent and able to work with the child. (Bond, 2010). It is also a time for you to consider how the children are in the world, how they are impacted and the impact they make. Below I have formulated a set of questions that may be of help with regard when making the assessment. In all cases I see the parents without the child for the first session. During the second session I will see both the child and the parents, although often the parents will leave the session after the contract has been agreed, part of the way through the session. This is to show the child that the adults, (the therapist and the parents), are trusting of each other and have an agreement to assist the child.

The Assessment Interview

The intake interview will help the therapists working with the child and the parents to obtain useful about:

The child's biological strengths and weaknesses
Family Environment
Parental expectations of the child

The reason for the referral

How does each parent view it?

How does the school view it (any other services or professionals)?

When did they first become aware of the problem?

Why are they coming for help now?

Parents expectations and attitudes

Expectations of cleanliness and conformity

Attitudes toward nurturing, autonomy, exploring, independence

Permission or attitude to genitally: sexual exploitation and pleasure permitted, encouraged or over stimulated, masturbation, sexual curiosity, family modesty / exhibitionism.

Parents families of origin

Family origin (both) and attitudes towards origin

What was your place and role of sib-ship?

What were you parent's expectations of you?

What relationship did parents have with their own parents?

How supportive were grandparents/ siblings?

Are there family problems, learning or emotional problems, substance misuse?

Length of courtship/partnership/marriage

The current state of relationship.

Unities/disharmonies in attitudes toward childrearing.

Similarities / differences in child rearing practices, expectations in both families of origin.

Questions re the child

Was the child wanted? Planned?

What type of birth did the mother/child experience?

Medical history: parents and child

Additional Disruptions (losses, separation, school etc)

Sibling relationships: (names, number, position in family, reaction to birth sibs, current relationships)

What relationships are important to the child?

What behaviours do you see?

What else do I need to know?

What do the parents want from this piece of work?

These questions, if asked in a questionnaire format, could potentially be quite overwhelming for the parents who may already be experiencing shame and sadness that their child needs professional support. I find, that asking general questions and expanding upon the answers means that the above information is gathered in an ordinary, narrative way that parents find easily manageable. If parents are concerned by the amount of questions you have asked about them I always explain that they are the blue print for their children. What they have done, their beliefs, will influence a child's way of being. Whilst in session you can speak at length with a child. You also have to gather all this information about the parents during this initial assessment.

I ask parents to complete my every-day contract that has been amended to say they are giving their parental consent to me working with the child. I write on the reverse of this consent form, in easily legible writing, the child's consent form. It is likely that it would say for a child under ten,

' I agree to working with Karen and know that she will talk to my mummy and daddy (if applicable) to help me.

I will be honest and I know I can stop the work if it becomes too hard.

Signed

As when working with adults, a copy of this contract is given to the child. If a child is over twelve then I use my ordinary contract with them, and discuss it, ensuring they understand, as well as a contract with their parents. The parents in all cases fill out my information sheet, which has details of addresses, GP, date of birth etc relating to the child. I *always ask* the child if they want to work with me. Many practitioners I have found do not. They assume that because the child has been brought to session they are willing. This can be a very valuable discussion, if the child does not want to be in therapy.

I also discuss with the child, how the sessions will be. Also the room they will be working in, where the toilets are, where their parents will be while we are in session, how long the session lasts for. I often say, ' you will be here for some weeks'.

I think that it is of value to ask the child why they think they are here and what they understand of the process and what they want from therapy. A useful guide is from Phillips and Cooke (2011)

1. Who is in your family?
2. What brings you here?
3. How often does this occur?
4. Who with?
5. How long has this been happening?
- 9 What are relationships like in your family?

Confidentiality

This can be a 'sticky' subject. I always tell the child that if I feel it is necessary for their benefit, I will talk to their parents about the work we are doing. I let them know if I feel they are in danger, I will also do what is necessary to keep them safe. (A child protection issue for example). Invariably, the parents will want to know how the work is progressing and from the information I have received during the sessions, I speak to the parents every 4 – 6 weeks. This will be a session for parents only, (and payable), when I can speak to them about the work and how they could help the therapeutic process by changing their behaviours or attitudes.

I generally do not give specifics, unless it is necessary. For example I may say to the parents, ' when I was exploring with your child about the sadness they feel, they said that you seemed to find it hard and you changed the subject quickly. This maybe that they need to know more about the loss and they are stopping asking, to protect you, rather than fulfil their curiosity and needs'. I rarely go into significant details with parents and find that is often not necessary, as they will know what is happening, although may not recognise the impact it has upon the child.

By the time that you have completed the second session, although you will be continually assessing your work, you, the child and the parents will have clear idea of what is expected.

Chapter Three

Planning the sessions

As is ordinary, sessions need to be planned. From the assessment sessions you will have formulated wishes and the desired outcomes of hopefully, both the child and their parents. This, of course, may be different from your therapeutic decision, re the therapy.

In my therapy room I see both adults and children and I often use my 'toolbox' for all clients, no matter what their age. I offer adults decaffeinated coffee; children water during the session. I do not allow food to be eaten, except if it is an experiment that I have planned. (For clients that are desensitising, they often cannot tell foods apart in a 'blindfold' test).

Sessions of an ordinary duration of 50 minutes may be too long for smaller children. I often ask parents to arrive for their child after 35/40 minutes. If the session is not ended they wait, in a waiting area until the session is completed.

Part of your planning needs to be ensuring that you have adequate and specific supervision for this work, so ensure that you have a supervisor that works with children in place. (See chapter 7)

You will need to ensure that the timing of your session is of value to the child. Later evening sessions would mean that the child may be too tired to participate fully. If the child is missing an activity, due to being in session, there may be a significant resentment at being in session! Check out these things before deciding upon a date and time.

When planning your sessions please ensure that you build the work around the actual child and not the 'issue'. It can easy to theorise and lose the child in the work, as there is so much theoretical material available. This theory can be useful as a guide and can reinforce your supervision. However it is in honouring the child, the actual work can be done.

As far as a theoretical framework of how to work with children, all that you would do with adults is applicable, whilst appreciating their developmental age and the specialist child knowledge you will have gained with training and experience. I think that the tenets described below is a good place to start no matter what theoretical model you use as a practitioner.

Attunement – recognising and verbalising what is happening for you and the child.

Emotional proximity-allowing emotions to be felt, seen and shared.

Challenge-when behaviours or actions/ reactions are 'odd', not ok or ordinary. Explore how they came to that situation and the choices they made.

Balance-ensure that humour, play and positive experiences are within the child's world.

Freedom of movement-don't allow yourself to be boxed in – if you are stuck, how can the child move on, change?

Being trustworthy-honouring the trust placed in the practitioner (also referred to as fidelity).

Autonomy-respect for the client's right to be self-governing (as long as no self harm or harm to others is occurring).

Beneficence-a commitment to promoting the client's well being.

Non-maleficence-a commitment to avoiding harm to the client.

Justice-the fair and impartial treatment of all clients and the provision of adequate service.

Empathise-have the ability to communicate understanding of another person's experience, from their perspective..

Sincerity- a personal commitment to consistency between what is professed and what is done.

Integrity-commitment to being moral in dealings with others, personal straightforwardness, honesty and coherence.

Resilience-the capacity to work with the client's concerns without being personally diminished.

Respect-showing appropriate esteem to others and their understanding of themselves.

Humility-the ability to assess accurately and acknowledge one's own strengths and weaknesses.

Competence-the effective deployment of the skills and knowledge needed to do what is required.

Wisdom-possession of sound judgement that informs practice.

Courage-the capacity to act in spite of known fears, risks and uncertainty.

A long list and I may have missed out many parts that you feel is necessary. However I see these as the significant principles of working with clients.

Chapter Four

Tools and toolboxes

As previously mentioned I have many tools to aid my work within my therapy room. I believe the greatest tools I have are my compassion, experience and therapeutic knowledge, alongside of my curiosity. Beyond these I also use sand trays, paper, pens, crayons, paints and beads (to make jewellery). I have an enormous collection of small figurines that I use also. I will use music, (either supplied by myself or the child), dance and role-play to promote an understanding of the child.

As stated earlier, I will also bring food into the work, to show how a client is not discriminating by doing a blind food test. (*A/ways* check out allergies before the session).

Carrell (2001) gives a wonderful overview of tools and how they can be used for working with both children and adults. I often use 'workbooks for children and would recommend Heegard (1991) and Sunderland and Armstrong (1997) for an amazing range of therapeutic books. Most of these books can be photocopied and when completed kept in a folder, specifically for the child. It can be the child's choice if at the end of therapy they keep these, or choose for you to keep their folder.

My first book that I used and is still my favourite resource to draw upon, is 'Windows to Our Children', Oaklander, (1978). It outlines a philosophy for working with a child that is inherent within Gestalt practice, which can be, without doubt, of significant value for all practitioners, no matter what their model.

Language

It is worth noting that children, developmentally and emotionally, may be unable to understand particular adult words. In an eagerness to please they may not ask you to explain certain words. It is therefore necessary to ensure that children understand you, by simply checking out and possibly getting them to say what the words mean to them. Also reminding them it is ok to check out things, both in and out of the therapy room, is a way for them to learn and more importantly to understand. See Faber, (2005) chapter 5.

Body work

In my therapy sessions I concentrate a great deal on body process. This can help a client understand the overwhelming feelings they experience. Often for children (and adults), they do not understand the feelings, even to the point of being unable to label them, however they do experience them. Useful books to mull over are by Rothschild (2000), Kepner (2001) and Kepner (1995) for this necessary work. I ensure within my work with either children or adults, that they do not need to be concerned re physical touch as I will only touch hands or appropriately hug, with consent. The majority of my work with children is either videoed or taped, with the child's knowledge. I explain that

this is for their benefit, as I can check between sessions by reviewing the material to ensure I am working as well as I can. The majority of adults and children get very used to this and accept it as ordinary, (which it is).

Chapter Five

Working with Adolescents

Working with children aged 12 and above can be very different from working with primary age children. All of the previous chapters can be of value when working with children of any age, I believe in working with adolescents there are other considerations.

Due to changes in the brain as children mature, the child may be experiencing the onset of puberty and the hormone 'rush' that change our children into adults. It is generally a frightening and inexplicable situation for many teens.

I often give the book, 'Blame my Brain', Morgan (2005), to parents who are amazed at the change from their sweet, adorable pre-pubescent child, into the 'monster' that lives in their bedroom, moody, challenging and anti-social with anyone outside of their (constantly changing) group of friends. This book explains how the changes that are happening to their bodies and most significantly to their brains, result in oppositional and very different behaviours. I agree with the author in wishing I had this book when my own children were at that age!

I have noted through years of practice that adolescents are happy to explain the latest game, teenage craze or idol, therefore it has not been necessary to keep fully up to date with adolescent culture. Having some idea does and that means just being aware of what is making the news. It helps adolescents to recognise the differences between adults and themselves if there are differences.

Being an adolescent is the time between childhood and adulthood. It is a time for exploration and testing the boundaries. Some children take this to the limit and generally when they do, it will mean there is a significant issue underpinning these behaviours. This could be a significant bereavement, attachment difficulties coming to light or, indeed, a medical problem, for example a loss of hearing/eye sight.

It is common for children of this age to feel pulled in between the two phases of life, of being a child or an adult. Their emotional needs may not have been met as a child and yet they are striving to be adults, often before their time.

As with all children they need to be heard, accepted and understood. They have a valid point of view that deserves to be listened to. It is our job as practitioners to hear what they have to say, understand and try and make meaning of their lives.

Their behaviours that have been reported by parents or professionals that have brought them to therapy, you will see in some way within the therapy room. They may be less violent or have less impact. However, look, listen and feel the contact the child is making, it will be there. When it is, it is of value to give an account to the child, they and the impact it has on you.

I always believe in working genuinely with children. This includes being honest at all times and working within a language structure they can understand. It is necessary to work in 'manageable chunks', so the child can process and feel able to go 'back over' difficult situations, so they truly understand and the work is integrated.

In the 'safe emergency' of the therapy room, it is paramount for the adolescent, as it is with any child, to feel safe and have an alliance with their therapist. They may want to check out the confidentiality clause, and again, this can be explained and how it works for their benefit.

Another wonderful resource is a group of books written by Adele Faber. I personally find, 'How to talk so kids listen and listen so kids talk' (2005) is valuable for myself and to hand to parents as an informative book. I have found most parents have purchased the book after reading it from my personal library.

As parents and adults from the time we give birth or a child comes into our home, we are preparing them to leave. That's why we teach children to feed themselves and teach them to cross a road, there will be a time when you are not there. This is known as the 'roots and wings' within attachment work. Many adolescents within the current society receive varying, mixed messages from their parents, teachers, peers and the media of how to be. It is worth finding out from your client, what different people expect of them and how they react to that expectation.

It may seem difficult when you realise an early developmental milestone has been missed for an adolescent. If it is to do with nurturing, using a sports bottle, that their parents have filled, can be an acceptable substitute for a baby's bottle. Creative thinking within and out of the therapy room and recognising your own style as a therapist can help each individual practitioner.

It is a regular occurrence that I give all my clients postcards from me, with my handwriting on to take away. As previously stated, this writing will be made more legible for children. As a transitional object, these can be of extreme importance to a client of any age. Some clients take small dolls or ornaments from my room. In cases where there is no object permanence this can be of extreme therapeutic value.

Consider with adolescents the possible, the physical, the psychological and practical aspects of all issues that are raised. Generally they will have an understanding of each aspect.

Therapeutic Considerations

- Establish safety for the young person outside of therapy as well as within.
- Teach the young person techniques to ground themselves to enable them to go on to process traumatic memories.
- Accept and honour their current defences and work to create more viable healthy ways of coping.
- Pace the work so as not to increase the pressure.
- A therapist needs to have a sound knowledge of theory and treatment models of trauma.
- Respect the client's unique experience even if interventions fail.
- Sometimes the young person just needs to tell and re-tell their story before therapy can begin, this takes time and patience.

(Phillips and Cooke, 2011)

Remember as an adolescent, your client will be experiencing a hormone rush that will make significant, physical and psychological changes. Some can be very frightening and incomprehensible to themselves and others. It can be of value to remind parents of how they experienced their adolescence, although parents and children 'swapping stories' of not ok behaviour can rarely be of value!

Sometimes even within a session you may notice that your client reverts to various emotional ages. Respond to each one accordingly, reminding yourself of the treatment plan. Ensuring that as your client is ready to leave the room, they are truly grounded.

Chapter Six

Trauma and bereavement

Trauma

Thank goodness it is rarely a one off event, which traumatises children. Unfortunately, if it is significant this can happen. When it is a single event this is known as a 'type 1 trauma'.

Research (Phillips and Cooke, 2011) has shown that violent televised or community events can have a significant impact upon children. It is more likely that it will be a repeated pattern of 'unexpected/never considered behaviour', that will traumatise children (type2 trauma).

The developing brain will dispose of synaptic nerves, that 'remember' events if they have not been stored by constant experience. In children, also the part of the brain that allows memories to be stored, the hippocampus, is not developed until between two and three years of age, however the amygdala which registers terror and fear is mature at birth. Therefore your clients may have no verbal memory, the fear is stored in their body. (Van der Kolk, 1996)

The hippocampus becomes extremely aroused and floods the child's body with the stress hormone, cortisol, which in turn keeps the child in a heightened and vigilant state. This can impact learning, the ability to regulate feelings and to be mentally healthy.

Trauma can arise from many things including

Bullying

Exclusion (from/by peers or family)

Physical, sexual, emotional and/or verbal abuse

Anything that makes a child feel worthless, unloved or unlovable

Insecurity

Endangerment

Belittling, degrading or ridiculing a child

Failure to be given emotional support, affection or caring

Neglecting mental, physical or emotional needs of a child.

Parental fighting

Lack of boundaries

There are other stressors too that can lead to a life long journey of depression and difficult behaviour often resulting in a chaotic or violent life style.

Some of these stressors are moving home often, sibling bullying, parental neglect, being ostracised by playmates or exclusion can be significantly traumatic for a young child. Long periods of times, forced to keep still is believed to be a factor that can lead to ADD/ADHD—especially in boys. (Phillips and Cooke, 2011)

Lack of stimulation, poverty, discrimination and fragmentation of the family can all have a negative impact upon children. Generally children will be aware of the arguments or split in the family before it is finalised by separation or divorce.

According to Herman and Miller, survivors of prolonged trauma must first create a safe place. Herman considers the remaining steps to be remembrance and mourning and reconnecting with the world, accepting the changes that the trauma has made in your life. Remembrance and mourning involves grieving both actualities and potentials that were lost; reconnection is a time of “I know I have myself” – a time for seeing the positive changes wrought by the traumas, celebrating the survivor self, and reconnecting/deepening intimacy with others in ways that were not possible before.

Miller sees recovery in three stages too: the outer, middle, and inner circles. The outer circle is a time for building safety and rapport and gathering basic information. Middle circle work involves focusing on current symptoms and how to handle them. Inner circle work, when trust is deepest, involves the sharing of shameful secrets and resolving the issues behind the trauma.

Bereavement

The concept of death from a child’s perspective is very different from an adult’s understanding of death. As the child grows and matures, his/her earlier ways of thinking about death will change. It is essential for the adult to have a sense of how children conceptualise death at different ages so that when the time comes to talk about death, whether of a pet or a loved one, the adult can respond in a manner appropriate to the child’s developmental age. The ages given below are not meant to be exact but rather representative of the differing developmental stages.

Young Infants – Birth to 1 Year Of Age

- Up to 6 months, a loss brings no response due to undeveloped memory capacity for specific personal relationships.
- Up to 6 months, there is no ability to conceptualise death.
- From 6 months to 1 year, a loss, like separation, may be felt, if at all, as a vague absence or experiential sense of “something different.”

Older Infants – 1 to 2 Years Of Age

- The death of the primary caregiver will usually result in displeasure and depression.
- Although a loss may occur, there is no ability to understand or attribute meaning to it.
- Infants can be influenced by the parent's tense and emotional grief reactions to a death in the immediate family.

2 to 6 Years Of Age

- Death is understood as temporary and reversible.
- There is no concept of a personal death; death is something that only happens to other people.
- Dead persons or animals are broken and can be fixed, or asleep and can be awakened, or gone and will be back.
- Well developed 4-6 years olds often think about, and are quite interested in, death and often want to see and touch dead things.

6 to 9 Years Of Age

- From 6 to 8 years, a clearer understanding of death is developing.
- There is an increased interest in the physical and biological aspects of death.
- "Magical thinking" predominates with the belief that thoughts can make things happen, even accidents and death.
- By 9 years of age, the child's concept of death is very similar to an adult.
- Death is not reversible or temporary but only happens to some, or other people.
- Death is often thought of as a person or a "ghost" figure.

9 to 12 Years Of Age

- Child's concept of death expands to that held in adult life.
- Awareness of the possibility of personal death now fully developed.
- An objective curiosity develops: "What does the body look like?" "Is the blood blue?" "The body stiff?" "Cold?"
- Even though there is a cognitive awareness of death and its universality and finality, there is a strong tendency towards denial.

- There is an increased interest in what happens after death.

(www.umb-eap.org)

A practitioner will need to make sure that they are aware of the child's developmental age, in how they view and experience death. Then they can work in a way that will help the child come to terms with the loss.

In a younger child, remind parents to keep a routine and ensure that there are structures in your sessions. (A noticeable beginning, middle and ending.) Provide opportunities for your client to draw, play and talk about their questions and understanding of what has happened. Again I would consider using a book, such as Heegaards, 'when someone very special dies', (1991). Allow the child to verbalise thoughts and feelings, and, if necessary, identify them for the child.

Speak in concrete language, not euphemisms, such as 'Mummy has gone to heaven'. Ensure that you are aware of the parents spiritual beliefs and if appropriate discuss them. Be conscious of regressive behaviours

Make sure child' does not feel responsible in any way

Identify specific fears

Provide opportunity for play, drawing, art

Normalise feelings & fears

Address distortions & perceptions

Be honest and tell a child if you do not have an answer

Help to cope with impulse control

Help them share bad dreams

Help them with positive memories of the deceased.

Model healthy coping behaviours

Avoid clichés; "Don't worry, things will be O.K.", "You're such a strong boy/girl"

Use specific, concrete words – not euphemisms; Avoid "Grandma went to sleep and is now in heaven", "The angels took her", or "Only the good die young" (Does that mean I *have* to be bad or I will die?)

Bowlby (1963) suggested that children who lost their mother in their earlier years have a predisposition to being 'clingy'. In turn when they have future

relationships, their 'clinginess' drives others away, therefore re-enacting the cycle of loss.

Van Eedewegh, et al, (1982) purports that adolescent males have difficulty with their sense of identity if their fathers are lost at this age.

Working with a sense of immediacy, honesty and consideration will help the child to express and manage his grief and loss.

Chapter Seven

Self Harm, Disclosures and Supervision.

When a child self harms it is both distressing, shocking and confusing for the child and the adults around them. In the Gestalt model this can be a form of retroflection, (page 4), when the child cannot express their emotions and turns on to them self.

Phillips and Cooke, (2011) comment on the lack of self-esteem and anger that many children who self harm have. They suggest that there are ways to help the child consider their actions and change their behaviours to release their feelings in a different way that can stop, or lessen the damage.

It is vitally important that the child recognises that when they self harm, adults will consult each other and work towards them stopping these behaviours. It will have been discussed at the initial contract, (do no harm to yourself) and as a professional you will engage and seek advice from others. All adults that are in the child's life need to be told of the self-harm and a strategy for each worked out and abided by. Regular meetings (without the child present) can keep people up to date with the progress and these can support the adults, as well as the child.

Useful questions to work with the child are;

Why do I feel I need to hurt myself? What has brought me to this point?

Have I been here before? What did I do to deal with it? How did I feel then?

What I have done to ease this discomfort so far? What else can I do that won't hurt me?

How do I feel right now?

How will I feel when I am hurting myself?

How will I feel after hurting myself? How will I feel tomorrow morning?

Can I avoid this stressor, or deal with it better in the future?

Do I need to hurt myself?

(Phillips and Cooke 2011)

There are many books and articles available that deal with this very complex subject, and you may find that extra supervision is required to help you, as a practitioner to work with this issue.

If a child discloses to you that they are the victim or survivor of abuse, remember that you have a significant duty of care. You must remember that

they are being very brave in disclosing this information. They may also be feeling some shame, responsibility, guilt, powerlessness, scared, disgust (of them selves and the perpetrator/s). You may feel a sense of outrage, disgust, sadness and anger, or even disbelief. It is imperative that you stay calm and reassure the child that you will do what you need to do, to keep them safe. Your initial reaction may influence how the child views themselves and the situation.

Reassure the child they have done the correct thing by telling you.

Listen to the child.

Emphasise that it was not their fault and they are not 'bad'.

Tell the child that you believe them.

Let them know that you will take this seriously and will inform the correct adults and authorities to make this stop/bring the perpetrator/s to justice. (Social services and the Police, your supervisor and if appropriate, your line manager).

Tell them that you will stay, be with them (they may feel you are revolted by them, rather than the acts forced upon them).

Allow them to tell their story, in their words. If necessary take notes at this time even if that is unusual. Tell the child it is because this is very important.

Acknowledge their bravery and their distress

Tell them you know there are some adults who are 'not ok'.

Do not dwell on the sexual/violent aspect of this, or assume – listen to the child.

It is imperative that, as a trustworthy adult, that you manage your own feelings, so your words or actions do not interrupt the child or make them feel that you are overwhelmed by their disclosure.

Thank goodness, disclosures do not happen on a frequent basis. However be aware that they do occasionally and be prepared for this event. You will need to report your discussion and the disclosure to the relevant authorities. During this period be in contact with your supervisor and allow yourself time and energy to work through what this has meant to you and how it may impact your work.

Not all supervision needs to be critical and immediate as the above situation. It is crucial that you are in regular supervision as expected by your code of practice and ethics of your regulatory body. Ensure that your supervisor is

someone that you trust, can work with, can learn from and meets your requirements.

Supervisors do not need to be of the same discipline as you and they will need to know you and your model, to help your practice. Both individual and group supervision are of value to practitioners when working with children. Many supervisors refuse to supervise work with children if they do not have the relevant experience themselves. This may mean that you have different supervisors for your adult work and work with children.

Most regulatory bodies suggest the amount of supervision required in ratio to the number of therapeutic hours you have worked. When working with difficult or new cases, particularly if they 'touch' upon your own story, extra supervision may be required, or indeed, personal therapy to support you.

It is often of value to work out before beginning supervision meeting what you want/need from that session. Is it education, is it emotional support, or is it to release your anxieties? What is hard and what do you find easy in your work? An exercise to notice which clients you rarely, if ever bring to supervision may be illuminating.

I have often noted in my practice as a supervisor and trainer that many practitioners fail to remember that we have a duty of care to ourselves. We cannot support others if we do not care for ourselves. Many of my clients and supervisees will note my words, 'You cannot draw from an empty well', (thank you Annie McColl, personal communication, 2006.)

In practicing being kind and caring to your self, can model for clients a healthy lifestyle. Being drawn to an unhealthy work ethic can be tantalising, although rarely satisfactory. A healthy relationship with your supervisor can be both illuminating and supportive. It can be seen as a collaborative experience to aid your work and your self.

Peer groups and further training; be that another qualification, continuing professional development courses, or workshops, can enhance your work and knowledge.

Chapter Eight

Holiday breaks

Sometimes clients will be taking both arranged and unarranged breaks in their therapy. At time of discussing the contract, holiday breaks can be discussed. In my own practice I do not charge for arranged holidays, for either the client or myself.

I have found that some children can become distressed when I am on holiday and find it difficult to manage, when they are either becoming attached or are attached to me. It is at this time, that I may offer a small ornament, as a transitional object to help them remember I am in their life and I will be returning. When younger clients are just beginning the developmental milestone of object permanence, to have a break in therapy can be a potential cause of further psychological damage.

Of course, not all breaks can be planned; illnesses, bad weather that imposes an unforeseen non-attendance or plain refusal to attend may result in a fracture of the budding therapeutic relationship. I would suggest that an appropriate card could be sent to the child. When I say appropriate, it should not be overly sentimental or affectionate. It should be written in legible handwriting and I would strongly recommend that it should not be signed off with 'love'; there can be enough confusion regarding love in a young person's life, without their practitioner adding to the mystery.

Endings

As above, a card could be sent if the ending was abrupt and without planning. If there is a planned ending, there needs to be clear communication with the child regarding the date and how the end will happen.

I talk with the child and we consider together if the work is completed. This allows a child to feel empowered and recognise their part in the ending. A clear plan of the date is made and then I spend at least one session with the child reflecting on the completed work. This may include looking at worksheets completed or at pieces of artwork, if appropriate. During the final session or final two sessions together with the child we make an item to be taken away - this could be a paper mache item, a piece of jewellery, (threading beads to make a bracelet or necklace), or another appropriate article.

It is clearly explained that this is the final time I will see the child, as the work is completed – there are no gaps or 'maybe's'. Of course, there could a reason why you believe, or guess that the child may return at a later date. If this is the case, for whatever reason, then the goodbye is, 'until we meet again'. It needs to be contained by saying that there will be no communication between the sessions. Also that for the continuing work, the adults will make the decision, when, where, even if, you will work again with the child.

You will need to role model a good ending. So many people, young persons or older, have few good examples of an ok ending. Emotions of sadness and joy can be explored, along with pride and satisfaction at the completion of the work.

This will be recognition of the effort and change the child has made, not of your work. It is a celebration of the child, that they are moving on, able to manage within the world without your support.

I am sure that many of the children that you work with remain in your head and hearts, remembering with fondness their progress.

Working with children and adolescents can be tiring and difficult. The majority of practitioners who have adequate training and on going support, find that the satisfaction far outweighs the complexities and arduous training necessary to work with children.

Final words

I have enjoyed writing this short e-book and have found it informative and educational for myself. I now hope that you too, find it of value. There have been moments when I have wished to expand on subjects, feeling tied by the brief space I have. At other times this has been a relief.

I recognise the short comings of having only a number of pages to give an overview of working with children and this cannot and does not want to compete with books or training courses that fully explore this work. I wish for this to be a taster that whets, or refreshes your appetite for working with children and adolescents.

To all, go well

Karen F Burke

Useful links

The Manchester Institute of Psychotherapy

<http://www.mcpt.co.uk/> bob@mcpt.co.uk

Child therapy world

<http://childtherapyworld.com/>

United Kingdom Council of Psychotherapists

<http://www.psychotherapy.org.uk/>

The British Association of Counsellors and Practitioners

<http://www.bacp.co.uk/>

The UK Society for Creative arts and Play Therapy

<http://www.playtherapy.org.uk/>

The Theraplay Institute

<http://www.theraplay.org/>

Barnardo's

<http://www.barnardos.org.uk/>

Childline

<http://www.childline.org.uk>

NSPCC

<http://www.nspcc.org.uk/>

The C A B

<http://www.adviceguide.org.uk/>

Manchester Therapy Community

<http://www.manchestertherapycommunity.co.uk/>

Karen F Burke (MSc Gestalt Psychotherapy) is a psychotherapist, supervisor and trainer (UKCP) in private practice at The Manchester Institute of Psychotherapy, and an adoption charity. Karen's work is informed and enhanced by Bowlby's attachment theory that she has integrated into her work with adults, children and groups.

karenfburke@hotmail.co.uk

Karen can be contacted on 07774 878313

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