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Post Qualifying Certificate in Counselling Children and Young People

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Unit 3 Essay 1

Describe a specialist area of work with young people and evaluate the use of a variety of creative interventions in your working practice.

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'When reason sleeps, the image wakes' (Victor Passmore 1908 - 1998)

Promoting children's mental health within schools has important educational payoffs.

OFSTED suggest that early recognition of stress symptoms can assist future well-being, counsellors can influence school policies in ways which not only serve the best interest of individual clients but also the greater good of all young people in the school, as well as the whole school community (BACP 2002).

The Mental Health Foundation provides a definition where children who are mentally healthy have the ability to;

- Develop psychologically, emotionally, creatively, intellectually and spiritually
- Initiate, develop and sustain mutually satisfying personal relationships
- Use and enjoy solitude
- Become aware of others and empathise with them
- Play and learn
- Develop a sense of right and wrong
- Resolve problems and setbacks and learn from them

(Mental Health Foundation, 1999)

Mental health problems in young people can be emotional, conduct, hyper-kinetic, developmental, eating habit, somatic and psychotic disorders and PTS, they may be mild or they may have serious and longer lasting effects.

In schools, children experiencing mental health problems tend to be defined as having emotional and behavioural disability, although these are not synonymous (DfES, 2001).

For this essay I will focus on deliberate self harm (DSH, hereafter) and its effects on a young person's mental health. This will include the affects on a child's developmental stage and cognitive ability. I will also share my knowledge of the use of creative interventions when working with clients who DSH.

DSH is the repetitive, deliberate infliction of harm to one's own body. Injuries can be severe enough to cause tissue damage and include cutting, carving, scratching, burning, bruising, biting, hitting, bone-breaking, skin picking, hair pulling, head banging, branding and marking (Martinson, 1998). DSH can occur regardless of age, gender, ethnicity or socioeconomic status (Focus Adolescent Services, 2001);

much of the discourse is centred on adolescents, as this behaviour tends to begin during this period (Boesky, 2002)

Awareness around self harm amongst professionals who work with young people is increasing and as DSH appears to be more common much research is being done to understand the behaviour. Recent research of more than 1000 15-21 year olds commissioned by the Department of Health, shows that more than 50% knew someone who had self harmed. A study in the *British Journal of Psychiatry* in 1998 of teenagers presenting at A & E for treatment for self harm found that every three hours three young people self harm (Mind 2005).

In January 2005 a national inquiry by the NHS found that a tenth of 15 – 16 yr olds has deliberately hurt themselves. The NHS warned that self-harm was reaching epidemic proportions (TES, 2005).

In 2002, Childline stated that calls about self-harm increased by around 65% in two years (TES 2002), all this research suggests that in an average class of 20 pupils, two will deliberately harm themselves during their teen years.

So why do young people DSH? Self harm is thought to be a maladaptive coping mechanism that is utilized when the self-injuring

young person experiences highly stressful or emotionally overwhelming circumstances. Those who self harm experience tremendous tension and anxiety before the act, along with the intense preoccupation with injuring themselves. Many people report that the impulse to injure is irresistible and cannot be thwarted, they may feel no pain as the cut, burn or scratch is inflicted (Ferentz, R. 2002). Many young people who engage in DSH describe an immediate relief from psychological tension as the act is completed (Martinson, 1998). One of my clients explained that the sense of pain from the act of cutting is a component for relief and the bloodletting is necessary to release the internalised pain.

Adolescents DSH for a variety of reasons such as risk taking, rebellion, rejection of parental values, acceptance , desperation, anger, exam stress, sexuality and gender, punishment, guilt, self hate to name a few.

Contrary to popular myth, DSH is not an attention seeking ploy, most of it happens in private and most young people are careful to cover up the evidence. If it is an attention seeking behaviour then the reason for

why a young person so desires attention and will DSH is an area of exploration.

For some, self harm is a way of communication, a form of problem solving and a form of coping. DSH is trying to communicate intolerable psychological pain, feeling of not being able to cope or feelings of shame which is common in those who have been abused, it's almost like they want to make real their mental pain.

One of my clients explained that cutting and scratching gives her a sense of control as she feels she has no control in her life – her family constantly put pressure on her to achieve. She, like many other DSH takes time to prepare, it becomes a ritual and she has complete control of time and place. She uses a special blade and keeps it clean and safe with tissues, antiseptic and plasters. Once she has drawn blood she has feelings of overwhelming relief from her problems, she feels alive again.

DSH seldom use this as an attempt at suicide and again clients have told me that their self harming is a way of survival not an exit from life. Favazza (1996) suggests that 'a person who truly attempts suicide

seeks to end all feelings, whereas a person who self harms seeks to feel better'

Fortunately information around the subject of DSH is getting better; more research is being done around this particular behaviour and its symptoms.

The symptoms that are usually present for a diagnosis of DSH are a preoccupation with physically harming oneself; inability to resist these self injurious behaviour resulting in tissue damage; increased tension before and a sense of relief after self harming and having no suicidal intent. The diagnosis will be done by a Mental Health professional; young people's diagnosis is usually made by CAHMS (Poustie, A. Neville, R. 2004).

Because the act of self harming tends to be secretive the young person is creative in hiding their wounds, one of my clients said she never wore short sleeves even in hot weather and was often questioned by her peers.

The reason for why someone starts self harming may be different from why they continue to do it, self harming is an addictive behaviour, when we feel pain our body releases endorphins, natural morphine like

chemicals that act as painkillers, which may explain why many DSH say they feel euphoric after hurting themselves, a 15 yr old male client said he experienced a ‘rush’ each time he bashed his head or cut his torso.

Young people who self harm are often wary of going to hospital, a report in 2004 by the National Institute for Clinical Excellence found that half of those seeking treatment for their injuries received no follow-up care or psychological assessment and some staff where even unsympathetic (TES, 2005).

It is reported that schools are not much higher on the list of sympathetic institutions, statistics from the Samaritans shows that nearly half of the young people who hurt themselves tried to get help, but found it difficult to talk to teachers because they are too embarrassed or feel their problem is not important enough. Louise Carpenter from the NHS states that, ‘if a child is found with a knife in the toilets, then obviously the school will respond. But often these children don’t know how to describe what they are feeling; they can’t talk about it, which is why they are cutting themselves, and by taking

away the knife, the school is taking away one way for the child to cope' (TES, 2005).

Therapy is key support for a self harmer and there are various models which are suitable, some creative interventions assist in the young person exploring their unconscious.

Whilst working with a DSH one needs to fully understand the dynamics of the behaviour and provide structure, safety and consistency. One of the key factors is to offer support which is completely non-judgemental, the client's dignity and autonomy should be respected at all times, often DSH feel that their autonomy has been 'taken from them' (Female client age 13 yrs).

No intervention is known which can stop young people self harming completely, but there are therapies that can successfully reduce the amount a person DSH.

Cognitive Behavioural Therapy is often suitable for clients who are self harming, as it can be used to help combat the cognitive distortions such as self harm being the best way to manage ones feelings.

Sometimes it is worth the client exploring ways of which they can problem solve and work on themes which are known to be associated

with self harm such as hopelessness, relationship problems, school, guilt and anger. The Royal college of Psychiatrists define CBT as, ‘a talking treatment that emphasises the important role of thinking in how we feel and what we do. CBT involves identifying how negative thoughts affect us and then looks at ways of tackling or challenging those thoughts’ (Hawton, K. 2002).

When using CBT the therapist enables their client to focus partly on identifying the negative thoughts that lead to the self injury, recognising the distortions of reality that exist within them and then develop more realistic ways of looking at their lives. The other part of this kind of therapy includes helping clients develop new, more effective coping skills to replace their self destructive coping strategies.

With CBT sometimes appropriate contracts that encourage the client to write, draw and self soothe before engaging in DSH are more effective than contracts that demand the immediate closure on the behaviour. For clients who wish to change their behaviour it is worth offering alternative behaviours such as the use of puzzles or hand held games to distract the mind and occupy the hands. Writing feelings down in a

journal or writing poetry. One of my clients used to wear an elastic band and rather than cut she used to pull the band, she also used a red pen instead of a knife, but this was only done once she had began to explore her reasons for behaving in this way.

There are of course many creative interventions which can be used, such as visualisations, cognitive re-framing and also art is a very good media of expression in therapy and my clients have often used this as a valuable tool.

In art therapy images contain messages from the subconscious – hopes and fears needing to be known.

When thoughts are pushed aside images can emerge which may be symbolic aspects of self in need of recognition (Silverstone, L. 1997). Some of my clients who have self harmed have found that by shifting the thinking to the creative mode really helps them to explore their inner world. Often this is aided by a theme or a guided fantasy, whilst imaging the aim is to push aside censoring and even thinking. I have found the more a client can say, 'I have no idea what this image is about', the more likely it is to be about a great deal as the image releases, expresses and contains repressed material. Some purist

person-centred therapist define counselling as a process confined to words, in art therapy the image is a projection of the self made visible, and when incorporated into counselling dialogue, the meaning of the symbolic aspect can emerge and contribute significantly to the therapeutic process. As with words a person-centred art therapist respects the ability of the client to know herself, as talking therapy, the art therapist's task is to hold the mirror up and reflect, in this case to the picture, and to the client's process in creating the picture. The danger to identify and interpret is even greater when working with images, because their powerful emotive impact and awareness is needed to push our own reactions aside.

'Creating tends to be the act of the whole person. He is the most unified, most integrated. In moments of here and now we don't reject or disapprove, we become more accepting. Spontaneity allows honest expression of our whole uniqueness' (Maslow 1997). This is true when working with my own clients, in the moment they speak freely about their inner world through the image which is before them.

For a client who is DSH, the action may be a way of surviving and their trigger for this behaviour may be around abuse, a particular client

said they wanted to ‘dig out the badness’, they had been abused by a family member and they recognised their self blame through imaging and were able to identify objects that represented their abuser. A client may internalise her angry and aggressive feelings rather than channel them toward the abuser or non-protective parent. This can be for various reasons such as further abuse, rejection or abandonment; these feelings may result in the self injury.

Self mutilation seems most likely to occur with those children who have experienced a long standing, incestuous relationship where there have been feelings of attachment to or identification with the abuser, some pleasure associated with the experience, and a commensurate feeling of guilt and self blame at enjoying it or allowing it to continue (Wilson, K. Kendrick, and P. Ryan, V. 1997).

Play therapy has proved to be a very useful tool for young people in therapy, there are many variations of play therapy including psychoanalytical, object relations, cognitive behavioural, release play therapy and play related interventions. Various materials can be used to facilitate the communication between the therapist and client and to help the client’s understanding of the events. For example an

allegation of abuse could be explored through puppets or figures in a dolls house. The underlying assumptions are that a child can displace their emotions on to play materials and may have less anxiety in communicating for example with a puppet than directly with an adult. Children are less verbal than adults, particularly before a certain cognitive stage has been reached; by playing it's easier for the therapist to assess the child's level of understanding of a given situation. Marvasti defines play diagnosis as 'a technique to enable a child to reveal internal conflicts, fantasies, wishes and perceptions of the world' (cited in Wilson, K. Kendrick, P. Ryan, and V 1997).

A client who is DSH due to abuse may mutilate a soft toy the way they mutilate their body, making it less attractive and therefore less tempting. One of my clients aged 15 years old said she 'can love other people but not herself'. She felt different to other people as she felt dirty and ugly, like the doll in front of her.

Although an abused client's DSH may be identified as the expression of guilt and the need for self punishment, it is important to remain alert to the specific meaning the behaviour has for each individual. Whether it is an expression of anger at another, self blame, a means of

distracting oneself through inflicting physical pain from the inward psychic pain or a wish to get in touch with a physical sensation from which one has become attached. Extensive scarring serves as a constant reminder to the client of the abusive experience, it also signifies to the outside world that they are hurting and are in need of help.

Whatever creative intervention is used in sessions it is essential to avoid interpretation as an analytical approach to the client maintains the therapist as authority who stands outside the client's problem and interprets rather than empathises, Winscott comments 'If we can wait, the client arrives at understanding creativity and with immense joy, and I now enjoy this more than I used to enjoy the sense of being clever. The principle is that it is the client and only the client who has the answers' (cited in Wilson, K. Kendrick, P. Ryan, and V 1997).

When my clients are using art or play I avoid asking questions, it is their time and asking questions shifts the child away from immediate awareness of feelings and behaviour, the here and now experience would be lost in the client trying to give an explanation of it. Like in any kind of therapy it is essential to have very clear appropriate

boundaries when working creatively because only through a genuine setting of boundaries can the client learn to identify her own boundaries.

Carl Rogers said of creative therapeutic work ‘the human being has potentially available a tremendous range of intuitive powers. There is much evidence that we are indeed wiser than our intellects. We are learning how sadly we have neglected the capacities of the nonrational, creative metaphor mind – the right half of our brain’ (cited Silverstone, L. 1993).

Further to this I support Rogers’ assertion that some modes of counselling address only the verbal, the left side of the brain intelligence, is in my view this is of limited effectiveness. It is worth trying to incorporate the spontaneous intuitive right side of the brain wisdom, to elicit subconscious material vital for growth and integration. Having used art and some play therapy with a variety of clients, it is clear from the therapeutic work that creative intervention has been of considerable benefit, exploring material from the subconscious, bringing to awareness denied hopes and fears,

engaging with less inhibition and more freedom in talking about the image and discovering its purpose.

We can learn from our young clients, as they are still connected to their imagination and their creative world, they also tend to be quite congruent and honest, so we can learn from the child and strive to be the creative genuine person centred person our profession expects of us. Just to re-engage with a difficult memory by expressing it in art form, making it visible but contained within the boundary of the image brings elements of healing – its almost like if a door is opened what is behind it is transposed onto paper and then packed away and kept safe. This kind of therapeutic work is also client lead; the therapist is a facilitator and an observer. It is very important to go at the client's pace, particularly when working with young people who DSH or have been abused.

Art, a graphic language readily available to young people, elicits much when used in conjunction with the respectfulness of the person centred approach, an ideal combination for any therapy room.

Through art therapy one can understand oneself; one can be more empathic, accepting, and congruent and can re-activate our creative spontaneous wisdom as expressed in art form.

Louis Cabot said, ‘Somewhere in the centre of your soul is a sense of identity that you can never convey to another human being by words alone’ (cited Silverstone, L. 1993).

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