Eileen Wilson

ESSAY 2

Post Qualifying Diploma
In Counselling Children & Young People

Edinburgh: 2007/2008

Unit 2 - Essay 2:

Models and Settings for Counselling Children and Young People

Compare and contrast two models of counselling and assess their relevance to a particular counselling setting.

Word Count: 3257 (actual count)

Authentication Statement

This essay is an original piece of work. It is my own work and has not been submitted either in the same or different form to this in any other institution for any qualification.

Signed: ….…..Eileen Wilson (signed copy as other attachment)

Name: ……Eileen Wilson **…….. Date: ……29/03/08……..**

Introduction:

> *"It is important for the young therapist to avoid sectarianism and to gain an appreciation of the strengths of all the varying therapeutic approaches."* (Yalom; 2002, p41).

1b As stimulating as I find Yalom's statement to be, it is also highly important I take into account the weaknesses or contraindications of each model too. Long-term psychotherapy for example, might prove inappropriate for a drop-in counselling programme in a youth-club setting, as clients may attend irregularly. However, a cognitive behavioural or solution focussed model may be more appropriate in this setting, as clients could use the time in-between visits for practicing behavioural 'remodelling' for instance.

1b The approach whilst working with adults, adolescents and children will differ as well as the counselling setting. Firstly a young child will not have the extent of historical experience on which to draw as does an adolescent or adult client, and secondly the approach must be attuned, not only to the age but the cognitive ability of the child concerned.

For example, play therapy with a boy aged thirteen may be classed as inappropriate, although if he has additional support needs – this approach might indeed prove ideally suited to his developmental stage.

3 *"…the bulk of research points to the fact that the most important factor in effective psychotherapeutic work is the relationship between the client and the psychologist."*

(Clarkson; 1995, pviii).

5c Inferring the model is considered of secondary importance in the therapeutic process?

However,

3 *"….critics arguing against eclecticism warn that without a guiding theory clinicians can be vulnerable and directionless, bombarded with an unimaginable array of information and choices of interventions and processes."* (Cormack: 2003, p16)

1b The two models of counselling I have chosen for this essay are the Psychodynamic Approach viewed from an Object Relations perspective; Bowlby's Theory of Attachment in particular, and the Cognitive Behavioural Model.

The Psychodynamic Model is based on the psychoanalytic method developed by Sigmund Freud (1856-1939), which focuses on unconscious mental processes and their roots in the past history of the client (1993). The relationship (therapeutic alliance), formed between client and therapist is regarded central to the therapeutic process, as are the 'defence mechanisms': denial, projection, resistance, etc., employed as a 'shield' by the client to protect their 'ego structure'

from rupture. Behaviour is considered highly important, as is the belief that *all* behaviour has meaning (Gomez, 1997). Therapeutic recovery is achieved through the client's insightful relationship with the therapist, along with their ability to process and acknowledge childhood's hidden patterns of behaviour being replayed in the present.

Behaviour is also regarded as important to Cognitive Behavioural Therapists (Beck, *et al.* 1976); although the focus of Cognitive Behavioural Therapy (CBT) differs from the psychodynamic process, in the respect of shifting attention *away* from the underlying, introspective approach and thus concentrating *directly* on the links between the clients' pattern of undesirable thoughts, feelings and resultant behaviour. CBT targets this dysfunctional process and the methods being employed by the client to *maintain* these behaviours, through various practical methods with an aim to stimulate the client's ability to re-learn and change these unsuitable patterns. As a result, healthier ways of thinking, feeling and acting evolve.

I work as a volunteer counsellor within a city-based primary school, counselling P2 to P7 pupils. I plan to use one client case* from this practice, and aim to compare and contrast the appropriateness of each therapeutic model within this setting.

2

* *This is a client case I have worked with although names have been changed to protect the client's identities.*

The Psychodynamic Model:

3 *"As anyone who has ever planted a garden knows, you must first prepare the soil – make the soil fertile in order to foster health and growth. The same is true for children: they must have a context that promotes healthy functioning and development. Attachment between child and caregiver(s) is a major aspect of this crucial context. It is as basic as food and water, necessary for healthy development of the body, mind, relationships, values, and spirit." (Levy: 2000, xiii)*

In contrast to Freud's belief in the infant's instinctual *"sexual drive"*(1905); Object Relations theorists such as Bowlby (1969) and
4a others (Erskine, 1998; Fairbairn, 1952b, Guntrip, 1968/1992) felt that the newborn infant was driven by a desire to *bond* with others, suggesting that we are;

3 *"….'hardwired' at birth for social interaction"* and are *"attuned to the social responses that will be encountered."*

Bowlby (1969) described the *"lasting bond"* that developed between the infant and the attuned attachment figure a *"secure base"* from which the infant could safely explore their world.

As a consequence, these *"fulfilling experiences of contact"* become *"internalised as a 'working model' ";* a blueprint of care-giving

predictability imbedded in the psyche as "*secure attachment*" (Bowlby, 1988).

Disruptions to this process; such as violence, abandonment, neglect, etc. or where trauma resulting from the parents or carer's inability to regulate fearful and excessively over-exciting experiences, meant the formation of an 'adapted' working model within the child, i.e. one that becomes moulded to fit the situation experienced. This results in displays of *"insecurely attached"* behaviours, such as violence, withdrawal, psychosis or hyperactivity for example (Bowlby;
4b 1969/1982). Problems arise when these adapted behaviours are 'replayed' in other situations, the school playground for instance, often I see these client's for 10-minute sessions, or at some future point in adulthood.

Bowlby (1969/1982), Ainsworth (1978), Main and Solomon (1990) described four basic *"attachment patterns"* of *"separation anxiety"* displayed by an infant towards his mother;

- **Securely attached:** actively seeks contact
- **Avoidant:** turns away or refuses eye contact
- **Resistant/Ambivalent:** appears angry, initially seeks contact; then pushes or turns away
- **Disorganized/disoriented behaviour:** appears confused, frightened and may 'freeze' when mother approaches. May also

exhibit role-reversal or compulsive caring and become extremely sensitive to mother's moods.

The therapeutic approach is attuned to fit the client's presenting attachment pattern, although in essence, client recovery is assisted through the therapist's ability to:

- create a holding, containing environment,
- reflect, attune, be responsive and emotionally engaged, with an ability to encourage the child's reflective capacity.

The therapeutic process is *always* about:

- connections, not compliance.
- relationships, not lectures
- using myself openly, not for punishment
- staying emotionally positive and engaged, even in the face of challenges, proving the therapist's capacity to *"contain the child's love and hate"* (Bion: 2000)
- it's *always* about the child.

Conclusively, in an atmosphere of safety, the attuned, secure and responsive modelling and mirroring of the therapist, promotes and develops the client's reflexive functioning abilities. To facilitate this ability, the therapist uses transference and counter-transference to highlight the client's attachment patterns exhibited within *their* relationship. Consequently, these insightful 'experiments' helps create

new 'parental memories' within the child's psyche allowing previous *"dysfunctional internal working models"* to be reworked, integrated and internalised and healing to take place (Bowlby: 1986).

Lowald describes these, new;

> *"…powerful memories"* as *"…the basis for the child's definition of a loving relationship."* (*in* Russell: 1999, p131)

But as Hughes highlights;

> *"…the affective/reflective capacities of the therapist – must be*
3 *adequately developed if* [clients] *are to develop similar abilities within themselves."* (1989)

Walsh (2005) upheld that developing trust with vulnerable children is key to providing positive therapeutic recovery:

> *"Psychodynamic therapy helps the child look inward, to reflect on*
3 *his experiences, feelings and reactions. Its aim is for the youngster to gain insight into and understanding of his behavior and emotions, especially those of which he may not have been conscious, and to change them in some fundamental way."*

Cognitive Behavioural Therapy

1b

A significant feature of CBT, and in contrast to the psychodynamic
4a approach, is that it lies in the 'here-and-now', along with a belief in the

operation of 'meta-cognition'; or the ability of a person to be aware of and reflect on, his or her own cognitive processes. CBT is intended to directly target symptoms, reduce distress, re-evaluate thinking and promote more helpful behavioural responses. Bor (*et al.* 2002: 14) describes the counsellor's task, as helping;

> *"…the pupil identify what meaning the problem's have for them and to discuss the consequences of them."*

Unlike classic Psychodynamic therapy where the clients issues guides the session, CBT sessions are structured, with the therapist and client working together to identify the relationship between underlying negative thoughts and maladaptive beliefs causing and those maintaining the emotional disturbance, to see if they can be reframed. Bor *et al.* describes this process as forward thinking, hopeful and possible:

> *"..bringing to the surface his resources, strengths, skills, capabilities and coping abilities. The task of the counsellor is to restore and highlight these…"* (2002: 23)

Time-limited goals are then formulated with an emphasis on client-change by providing 'homework', hence putting what has been learned into practice between sessions. This experimental process encourages evaluation, hence the client learns self-efficacy and to attribute improvement to his or her own efforts. A trusting and safe therapeutic

alliance is viewed as an essential ingredient, as in psychodynamic therapy, although CBT does not recognized this as the *main* vehicle of change.

> *"The process which underlies all cognitive modification techniques is that of de-centring or distancing, that is the patient is asked to stand away from his thought or interpretation and examine it in a more realistic manner."* (Blackburn & Davidson; 1995, 78)

3

I feel 'meta-cognition' is more accessible to adults and adolescents; as young clients' may not possess the developmental ability to either reflect on or are in-fact even aware of their cognitive processes.

4b

However, I have found the Feelings Triangle below (fig. 1) to be particularly helpful with younger clients, as visualisation appears to assist with understanding this interlinked and 'cyclic' process. The aim of therapy is to help the client break this vicious cycle.

2

5c

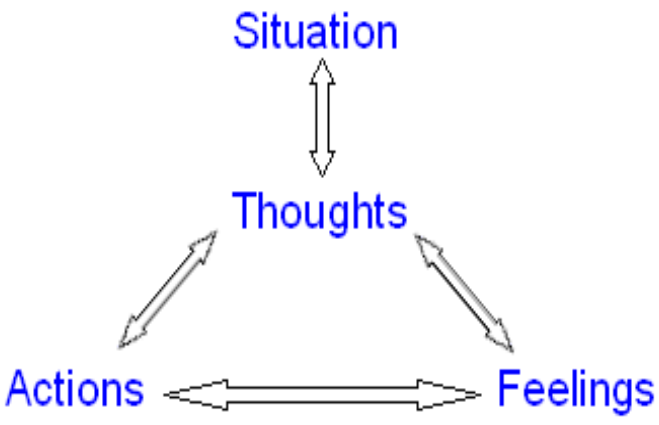

Fig. 1

Blank diagrams can be given out during therapy and completed by the client; especially useful when difficult situations arise between

sessions or during breaks such as holidays. This lets the child know he is kept 'in mind' by the therapist.

> *"The great array of both behavioural and cognitive techniques gives much flexibility to "mix and match" the therapeutic intervention. Good cognitive therapy should, however, always be carefully fitted to the individual client."*
>
> (Wills & Saunders 1997: 18)

Limitations of CBT:

1b Goisman *(et al.),* states that CBT and Psychodynamic Therapy are the most commonly used psychotherapeutic treatments for mental disorders in adults (1999). However, in children, although CBT yields many beneficial results, studies have proven:

> *"…the rates of positive outcomes for specific disorders are not satisfactory, especially if long-term outcome is considered. This is true for depressive disorders and for some of the anxiety disorders, such as social phobia or generalized anxiety disorder". (Davidson et al., 2004)*

3

To cope with these challenges more successfully and for adolescent clients suffering from personality disorders; such as borderline and avoidant personality disorders, Young (1994: 258), developed a more dynamic approach called Schema-Focused Therapy.

Compare & Contrast Psychodynamic & CB Therapy in a school setting:

5c The Psychodynamic model is generally classed as a 'talking cure' requiring long-term therapeutic attendance, although interpretive, non-verbal attributes of play-therapy can prove extremely beneficial when counselling vulnerable children within a modern setting. In contrast with both Freud and Erikson, Piaget feels that children are no *"less intelligent"* than adults however they do think about concepts in different ways (1953).

5c From an Object Relations perspective it takes time to build a trusting relationship and for the child to become accustomed to the consistency and 'containment' of the therapist before healing takes place. 3 Therefore in a school-based practice, this approach might prove unsuitable for clients who attend school infrequently, who have been sent for counselling against their wishes or where there are long client waiting lists for instance.

However, if session time is limited a condensed version of Attachment Therapy can be used, called *BABI – Brief Attachment-Based Intervention*; pioneered by Homes (2001). This involves a maximum of 10 sessions; themes are focussed through the use of an overarching metaphor arising from the client's life story. Worksheets, akin to CBT, are presented as 'homework' to promote healing (p151).

2 Hence, I feel, 'homework' and a time-limited approach, creates a healthy 'working alliance' between the two, and in some respects

3

4a divergent models discussed in this essay.

4b

For younger clients accessing private counselling, money can also play a part in the therapeutic model chosen by their parent's, so in comparison, time-limited approaches like CBT might prove cheaper and therefore more attractive.

4a However, working in a primary school setting can feel a little too accessible at times as parents can put pressure on the school, teacher and counsellor to come up with 'results'. As one angry parent stated at parent's evening, after working with her child for four sessions, *"I expected to see a difference in my child by now!"*

This statement serves to remind the counsellor the impact external factors have on the therapeutic context as the school client is very

4b much part of a wider social context. Holmes (2001), considered attachment an "*intergenerational process"*; therefore when I counsel a

5 child presenting with *"maladaptive behaviours"* it is impossible to disregard the influence their *parent's* attachment style has had on the child's current behaviour (Geldard & Geldard; 2004:17).

Although the advantages of schools should not be overlooked, they do not have a stigma of 'pathology' unlike a hospital environment and are a 'known quantity' for pupils and parents. I also feel accepted; a valuable

part of the school system, 'approachable' to parents and my client's teacher alike. In addition, my school provides long and short-term therapy for pupils, counselling and filial support for parents and therapeutic skills training for teachers, making therapy a fully systemic process. Other centres may not be as fortunate.

1a

Case Study:

Many children who experience emotional problems, present their difficulties in the classroom or school playground. Behaviour may become general disruption, aggressive or challenging, either towards other pupils, teachers or parents. Many become suspended or permanent excluded from school.

Alternatively, children can appear withdrawn, depressed, uncommunicative, lacking in self-esteem and difficult to 'reach'. Such behaviours can appear baffling or unclear; whether the child's' 'acting-out' is due to problems at home, emotional difficulties or from mental ill health.

2

I work with both long and short-term clients, and find that when Brief Counselling is required, the element of 'homework' integrated from cognitive behavioural therapy has been helpful. Mood diaries or logs can also highlight how the client's underlying negative thoughts can determine maladaptive beliefs and resultant behaviours. These elements integrated within a 'secure based' attachment framework,

1a
1b
5c

1a even in brief-therapy can promote client resolution and therapeutic healing as the following case study illustrates.

1b

2 Janice and Elaine were nine and eleven when undergoing counselling, their younger sister Beth, three attended a local nursery school. In their separate schoolrooms, both sisters appeared quiet, calm and contented, yet at home their mother described them as *"horrible….constantly fighting and verbally abusive"* towards herself and one another, she was at her 'wits-end'. The girls agreed to attend eight therapeutic-play sessions with me, although appeared resentful of my intrusion into their 'war'.

1a We started the first session by agreeing among other aspects, firm boundaries of physical and verbal 'contact'. Due to the limitations of time therapeutic 'goals' were agreed; the sisters really did want to be friends and make their mother 'happier'. During this session I noticed Janice appeared in competition with her older sister, describing herself as the best, quickest, prettiest, etc. these 'insults' resulted in Elaine physically attacking her younger sister. Calmly I reminded them of our agreed boundaries, and the girls fell silent.

2 From an attachment perspective I used myself as a safe and secure container, gently 'holding' the rage that appeared present in the room.

4a

4b Although underneath, I was very much aware of the urge to

5c countertransfer that competition, rage and frustration by leaping up and trying to 'control' the situation by shouting! Instead I used my

countertransference reaction to 'wonder aloud' if mum would have done *"just that?"* the girls admitted that mum usually screamed at them to *"stop"* then feel regretful.

At this point I introduced a CBT aspect, by asking them both to complete the Feelings Triangle (fig. 1). Janice described herself as the *"invisible middle child"* that needed to be seen and acknowledged by mum; although previous 'experiments' proved this would not happen, she antagonised her sister to *get* a reaction, even-though it resulted in her mother's 'negative attention'. Conversely, Elaine felt stupid, unattractive and *"inferior"* to her younger sister and described Janice as getting all mum's attention; feeling powerless and outdone made attacking her sister her *"only"* option.

4a Through this exercise, both girls identified a connection between their thoughts, feelings and actions, were able to look at other options, formulate and *choose* new ways of thinking and behaving that resulted in greater acceptance of themselves as *individual* beings.

4b After the girls second session, I suggested to mum that a local parent service currently had space available; she could access therapeutic support for herself? She agreed wholeheartedly.

By session five, Janice and Elaine were fighting less at home, with mum describing herself as feeling calmer and more in control of her own competitive feelings and the affect they had on her daughters. Over

time, each person discovered her own different and in-fact complementary qualities; consequently admiration increased and competitive behaviours diminished.

However, if time had allowed, I would have chosen to work long-term
5c with these client's, and together with their mum during the final sessions too, but am bound by the settings restrictions. I have to remember, as in Winnicottian terms (2005); I should aim to be a *'good enough'* counsellor as ideals are not always possible.

By the time therapy ended, both sisters felt secure enough in themselves and mum to ask for what they needed, 'fighting' for her
4a
4b attention was no longer required. Thereby proving I feel, the provision of a 'holistic', integrative and systemic therapeutic service within the "secure base" of their school proves an ideal arrangement.

Conclusion:

5
I have heard classic psychodynamic therapists describing CBT as *"shallow"*, depicting the results as *"short-lived"* in comparison to psychotherapy. Although I can see where these ideas originate, I firmly believe that running a 'competition' between models is of no consequence in a modern setting, as I feel the case study above shows how both models can be integrated successfully even in brief-therapy.

I prefer working long-term from an attachment theory basis with children, but the demand for therapeutic support in my setting has

escalated. At the last count 65 children have requested short, drop-in sessions; I can see three long-term clients and at the most six short-
4a term cases per day. In this situation CBT comes into its own as a
4b valuable part of the school's and pupil's support system. Being rigidly psychodynamic in this setting is unrealistic.

1a It is suggested by Wolf *et al.* (1990) that children accessing therapy
1b after the age of eleven have a much harder job 're-wiring' their behavioural patterns as *"neurological pruning"* of 'unused' parts of the brain has already started to take place.
2

I believe this statement further supports the urgent need for counselling services in all primary schools, with availability made for the child's wider social 'family', not only by means of cognitive behavioural or psychodynamic models, but from a broad therapeutic
5c base with attuned, flexible and creative counsellors.

> *"…there is a host of generic tasks and skills that can be brought to bear in any client encounter. These primarily concern problem exploration and definition, leading to problem management. Of*
> 3 *far greater relevance is an ability to relate to a troubled child or teenager, his parents and school teachers, and having the confidence and resources to clearly define the problem."*
> (Bor *et al.* 2002: 7)

Bibliography:

Beck A. (1976): ***Cognitive Therapy and Emotional Disorders:*** International University Press, New York

Bion W. (2000): ***Clinical Seminars and Other Works:*** Karnac, London

Blackburn Ivy-Marie & Davidson K.M. (1995): *"**Cognitive Therapy for Depression and Anxiety":*** Blackwell Science; Edinburgh.

Bowes P. (1999): ***The Psychodynamic Model - Health and Un-health*** *;* Private publication, Edinburgh

Bowes P. (2004): ***The Polarity "Health v Unhealth" Within Different Psychological Models:*** Private printing, Edinburgh

Bowlby, J. (1969/1982). ***Attachment and loss: Vol. 1. Attachment.*** Basic Books, New York

Bowlby J. (1988): ***A Secure Base - Clinical Applications of Attachment Theory:*** Routledge, London

Clarkson P. (1995): "***The Therapeutic Relationship":*** Whurr, London.

Cormack E. (2003): ***The Cognitive Behavioural Model – Health & Un-health*** *:* Private publication, Edinburgh

Cutler, J.L., Goldyne, A., Markowitz, J.C., Devlin, M.J., & Glick, R.A. (2004): ***Comparing cognitive behavior therapy, interpersonal psychotherapy, and psychodynamic psychotherapy.*** American Journal of Psychiatry, *161,* 1567-1573.

Erskine A. & Judd D. (1994): ***The Imaginative Body;*** *Psychodynamic therapy in health care:* Whurr, London

Fairbairn W. (1952b): ***Psychoanalytic Studies of the Personality;*** Routledge london

Field, A. (2003): Psychology Study Texts: ***Clinical Psychology:*** Crucial, London

Freud S. (1905): ***Three Essays on the Theory of Sexuality*** http://psychology.about.com/od/profilesofmajorthinkers/p/freudprofile.htm

Freud S. (1993): ***Historical and Expository Works on Psychoanalysis*** (Penguin Freud Library): Penguin, London

Geldard K. & Geldard D. (2004): ***Counselling Adolescents*** (2nd Ed.): Sage, London

Gomez L. (1997): ***An Introduction to Object Relations***: Free Association Books, London

Guntrip H. (1992): The concept of psychodynamic science, ***In Schizoid phenomena, object relations and the self***: Karnac Books, London

Holmes J. (2001): ***The Search for the Secure Base, Attachment Theory and Psychotherapy:*** Brunner-Routledge, Hove and New York

Hopper L. (2007): Basic Texts in Counselling and Psychotherapy: ***Counselling and Psychotherapy with Children and Adolescents:*** Palgrave Macmillan, Hampshire

Hughes D. (1998): ***Building the Bonds of Attachment; Awakening Love in Deeply Troubled Children:*** Jason Aronson Inc., Northvale, N.J.

Levy T. M. (2000): ***Handbook of Attachment Interventions:*** Academic Press, London

Mabey, Sorensen, B., (1995): ***Counselling For Young People***, Open University Press, Buckingham.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. *In* M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), ***Attachment in the preschool years*** ; Chicago: University of Chicago Press.

McMahon W. (2007): Bowlby's Contribution for an ASBO Age; ***Attachment; New Directions in Psychotherapy and Relational Psychoanalysis***, Vol.1 No.2, July 2007, Karnac, London

Piaget J. (1953): ***Logic and Psychology:*** University of Manchester Press, Manchester

Russell P. (1999): ***Trauma, Repetition, & Affect Regulation, The Work of Paul Russell.*** (Edited by J.G. Teicholz & D.Kriegman), Rebus Press, London

Schwartz J. (2007): Conference Review; 2007 International Attachment Conference 11-13 July, Changing troubled attachment relations: views from research and clinical work. ***Attachment; New Directions in Psychotherapy and Relational Psychoanalysis***, Vol.1 No.3, Nov. 2007, Karnac, London

Yalom I.D. (2002) "***The Gift of Therapy, Reflections on being a Therapist***.: Judy Piatkus (Publishers) Ltd; London.

Walsh, B.W. (2005): ***Treating Self-Injury: A Practical Guide:*** Guilford Press, New York

Wills F. & Saunders D, (1997): ***"Cognitive Therapy, Transforming the Image":*** Sage, London

Winnicott D. (2005): ***Playing and Reality***: Routledge, London

***** Evidence based information; regarding the comparisons and contrasts between Psychodynamic and CBT approaches gleaned from:
http://www.klinische-psychologie-mainz.de/abteilung/downloads/leichsenring_06.pdf

Leichsenring F, Hiller W, Weissberg M., Leibing E: (2006): Literature Review; Cognitive-Behavioural Therapy and Psychodynamic Psychotherapy:Techniques, Efficacy, and Indications: ***American Journal of Psychotherapy, Vol. 60, No. 3,***

Woolf, S.H., Battista, R.N., Anderson, G.M., Logan, A.G., *&i* Wang, E. (1990). A report by the Canadian Task Force, ***Journal of Clinical Epidemiology,*** *43,* 891-905.

Young, J.E. (1994). ***Cognitive therapy for personality disorders: A schema focused approach*** (revised edition): Professional Resource Press, Sarasota USA