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

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Essay 2
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" *If we could only learn to respond effectively to children at the crisis point in their lives which brings them to us, and at the subsequent crisis points which are part of growth, we might save many of them from becoming clients in one capacity or another for the rest of their lives.* "
(Winnicott, C. ' *Face to face with children*' *In Touch with Children*, 1984 p.19)

Each of the many counselling approaches has application and efficacy for different situations but aspects of each model may also have drawbacks depending on the age and developmental stage and needs of the child and the setting in which the counselling takes place.
All children and adolescents have a family or carers on whom they are dependant and who have played and will continue to play the major role in the social development and experiences of the young person. The family form part of the counselling setting which includes the child's difficulties in conjunction with the circumstances surrounding their attendance for counselling and the arena within which the counselling takes place.

"*Children cannot usually leave their families. They are dependant on them, and their families generally provide the main social system within which they grow and develop.*"

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(Geldard, K., Geldard, D., *Counselling Adolescents,* 2004 ch. 6 p.55)

The subject of this essay will be the person-centred and cognitive behavioural models.

Essentially the person or child-centred approach extends the core conditions of empathy, unconditional positive regard and congruence to the child, facilitating, in a reflective and non directive way the child's exploration and harmonising of her emotional and personal issues that have arisen from her life's experiences.

"…*the aim is to help the client to unravel the 'personal theory' which he has constructed around his own experiencing*."
(Mearns, D. & Thorne, B., *Person-Centred Counselling in Action* 2000 p.5)

Cognitive Behavioural Therapy, whilst offering understanding and acceptance explores and challenges the child's cognitive experience of the world, linking cognitions to feelings and actively identifying ways of modifying her responses to life events.

"*How children interpret their experiences profoundly shapes their emotional functioning*"
(Friedburg, R. D., & McClure, J. M., *Clinical Practice of Cognitive Therapy with Children and Adolescents. The Nuts and Bolts,* 2002 p.4)

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The person-centred counselling approach was conceptualised by Carl Rogers. The central belief revolves round the idea that each individual innately strives towards self actualisation, in other words, to be the best that she can be. In order to work towards this all the experiences that an individual has should be internalised congruently, without distortion, thus allowing an honest self concept to be developed. Having a true picture of herself and her self worth rids the person of the tensions that arise from denied and distorted views of the world and the consequent dysfunctional actions and reactions to events which may result.

"*The person-centred counsellor, however, sees destructive behaviour and feelings as simple manifestations of the person who is by nature essentially constructive and self-preserving when that person is functioning under unfavourable conditions."* (Mearns, D. & Thorne, B., *Person-Centred Counselling in Action* 2000 ch.1 p.17)

The person (or child)-centred counsellor believes that each individual will best know how to deal with their life situation as only they have full knowledge of the complexities of their relationships and way of life. The practice places great emphasis on the therapeutic relationship between therapist and client allowing the child to tell her own story in a safe way. The medium of play is often used in child-centred therapy. The therapist offers a warm, genuine and empathic setting using a non-judgemental and non-directive approach. By fully accepting the child's story the child is left in charge of her own information.

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"…*the approach lays primary stress on the quality of the relationship between counsellor and client."* (Mearns, D. & Thorne, B., *Person-Centred Counselling in Action,* 2000 ch.1 p.5)

Active strategic interventions, questioning and explanation do not feature in the child-centred process.
The use of accurate listening, congruence and reflection, allows the counsellor to facilitate the child's unfolding of difficulties in such a way that the child may then see different ways of dealing with them.

Stella, aged 13 years, was causing disruption at home, putting stresses on her mother's second marriage. The family comprised Stella's older sister, step-sister and two very young half sisters. Stella had been made to give up her name, at home, in favour of a nickname which she hated, because her step-sister was also called Stella. Both parents were unemployed but non-the –less the older girls were expected to do a large portion of the house keeping and child minding. They lived in inadequate accommodation three miles from the town.
The counselling relationship had to be built up painstakingly whilst Stella, who had many reasons for not trusting any adult, slowly described her life. Stella's father, now dead, had been abusive. Her step father disliked her and was known to be verbally and physically threatening to the youngsters. He regularly removed Stella's books, her main pleasure, because he was not a book reader himself and seemed angered by Stella's interest.
Initially much of Stella's story was couched in fantasy which seemed to function as a pseudo-protection from harm and fear.

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She 'was shot by an air rifle but the pellet just bounced off' her; a sharp kitchen knife did not cut her skin although her step-father had cut himself with it earlier; the boys she played football with never hurt her however hard they kicked her!
By accepting her story as her experience but gently reflecting on the likelihood of not being harmed by blows and sharp objects, Stella gradually began to accept reality. By constantly re-enforcing her value and building her self-esteem she seemed more able to deal with her life in a realistic way and her need to be disruptive at home became less. Stella seemed to benefit from knowing that the way she was experiencing life was true and by accepting this truth she was able to value and believe in herself and accept the counselling support in a more genuine and helpful way.

"…*once the child has undergone some personal change, however slight, his environmental situation is no longer the same.* …..*Once he is differently perceived, he is differently reacted to, and this different treatment may lead him to change further."*
(Rogers, C., *Client Centred Therapy,* 2001 ch.6 p.239)

The experience has been likened to a journey of self discovery which informs the behaviour of the child.

"*The* (non-directive)*play therapist may be seen not so much as an expert evaluating the play and unravelling the child's trauma, but more an enabler and co-explorer, trying to follow the child's lead rather than to control the play or alter the child"*
(West, J., *Child Centred Play Therapy,* 1996 ch2 p 18)

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Cognitive behavioural therapy was developed by Aaron Beck (Friedburg, R. D., & McClure, J. M., 2002 ch. 1 p.2).The underlying theory of this approach is that behaviour and mood are largely the result of the cognitive processes with which we interpret the environment that surrounds us. The therapist, whilst offering as in the child-centred approach, a safe environment, acceptance and congruence, will actively challenge self-destructive and negative thought processes resulting from 'schemas' (Young, J.1990), reinforced, learned patterns of irrational core beliefs built up during childhood. These thought processes become 'automatic' thoughts resulting in a repetitious scheme of responses. The therapist seeks to facilitate the child's own understanding of her behaviour and feelings and thus effect a change of view of the way in which the world impacts on them. This seeks to alter irrational into rational beliefs, which are less likely to result in poorly adapted behaviour and disorders such as depression that accompany them.

'*This* is encapsulated in the schema-focused work of Young (1990), who proposed that "*maladaptive cognitive schemas that are formed during childhood lead to self-defeating patterns of behaviour which are repeated throughout life."* (Stallard, P., *Think Good-Feel Good,* 2005 ch.1 p.3) (Young, J., *Cognitive therapy for personality disorders: a schema focused-approach,* 1990)

The cognitive therapist also builds a therapeutic relationship, extending a warm empathic and genuine listening atmosphere, a

safe place in which the child may tell her story, in the same way that the child-centred therapist does.

'…"*slighting the therapeutic relationship"* (Beck, A.T. et al p.27) is a common therapeutic pitfall.'
(Beck, A.T. et al *Cognitive therapy and the emotional disorders,* New York: International Universities Press) (Friedburg, R. D., & McClure, J. M., *Clinical Practice of Cognitive Therapy with Children and Adolescents. The Nuts and Bolts,* 2002 ch.3 p.34)

The cognitive approach also sees the process in terms of therapist and client on a joint voyage of discovery.

" *Therapists and children are true partners in the therapeutic journey.* "
(Friedburg, R. D., & McClure, J. M., *Clinical Practice of Cognitive Therapy with Children and Adolescents. The Nuts and Bolts,* 2002 ch.3 p.34)

The cognitive therapist uses a system of guided discovery and collaborative empiricism. In these systems the child is given tasks such as homework where diaries of activities and mood are kept, exercises in behavioural responses and Socratic questioning, to challenge her core beliefs, automatic thoughts and seek explanations of feelings and behaviour. The therapist actively aids the child to identify goals, quantify feelings and rate moods and collaborates in sorting through ideas of importance that occur to her whilst she tells her story.

"*The overall purpose of cognitive behavioural therapy is to increase self awareness, facilitate better understanding, and improve self control by developing more appropriate cognitive*

and behavioural skills." (Stallard, P., *Think Good-Feel Good,* 2005 ch.1 p.7)

Penny, aged 10 years, felt that if someone did not want to play with her in the playground then 'no-one' liked her. Penny's father who died some years earlier had physically abused her and her mother refused to care for Penny, saying that she was a nuisance because she asked for 'things' such as clothes, food and attention. She sent her to be looked after by her grandmother. Penny had learned in her early years that to ask for anything for herself often elicited a bad response and made her feel disliked. For Penny to think that she was disliked by 'everybody' whenever a personal request was refused was an irrational core belief giving rise to an 'automatic thought 'likely to be founded on these early experiences when she was rejected by all the significant people in her life at the time. Cognitive exploration of this belief slowly gained credence with her and her self-confidence improved as she stopped discarding her whole 'self' each time she encountered a rebuff.

This view of life, however, could also be seen from the child – centred perspective as an example of Roger's description of 'conditions of worth' where a child develops her sense of self by the repeated attachment of approval or disapproval, love or withdrawal of affection, to her actions, by the significant people in her life.
Penny, being offered the core conditions, may have benefited from reflective exposure of these conditions of worth. By beginning to discard, as the likely artificial constructs of her parents' care, her original sense of self, she might be able to rebuild a new, accepted sense of herself. With a positive

feeling of self-worth Penny may then be able to cope with the rejections in the playground without distorting the experience.

"*As infants we begin to acquire* conditions of worth. *We learn from experience that we are only acceptable as long as we think, feel and behave in ways that are positively valued by others. …Experiences and feelings that match these conditions of worth are perceived accurately and are accepted, but those that are contrary to them are distorted or denied completely. This process can be thought of as the beginnings of psychological maladjustment, when there is a state of incongruence existing between 'self' and experience."*
(Merry, T., *Learning and Being in Person –Centred Counselling,* 2000 ch.2 p19)

Both approaches encourage the idea that the rationale for change comes from the child's own insights rather than the therapists.

Ruth, aged 11years, had disturbed sleep patterns. She feared her mother dying. She revealed that her mother suffered from diabetes and had had a hypoglycaemic attack which Ruth had dealt with by giving her mother the appropriate glucose drink. As she spoke about this she said that she feared the diabetes may make her mother die. Then she realised for herself that she had been able to do the right things and that her mum had given her the correct instructions. When we talked about 'what if' she (Ruth) wasn't there she recognised the source of her fear and, whilst acknowledging that there are no certainties in life, she was able to identify all the safety precautions that her mother and father had put into place. Ruth began sleeping well again.

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"*Emphasis is placed on the collaborative aspect of the approach, on the assumption that people learn to change their thinking more readily if the rationale for change comes from their own insights rather than from the therapist.*"
(Dattilio, F.M., & Padesky, C.A., *Cognitive therapy with couples.* 1990 p.5)

The school setting may involve seeing children between the ages of 4 to 18 years of age with widely differing problems. The school often sees the counsellor as someone who will 'fix' a child's dysfunctional behaviour and then return her to the education system.
Often schools have difficulty in providing adequate privacy with other calls on time and room space.
Working as a nurse within the school setting allows confidentiality for the child and the contents of the counselling session. It is, however, helpful to work with staff and parents as closely as possible, sharing appropriate information with the child and parent's permission with agencies involved with the child's care. The same level of confidentiality is also afforded to clients referred by the GPs.

Costs are a consideration when linked to the choice of therapy unless the therapist is working on a voluntary basis. A lengthy therapy is clearly more costly. The type of therapy used, however should always be appropriate and should the more time restricted cognitive behavioural therapy be deemed unsuitable another time limited approach such as solution focused brief therapy may be preferable to the child-centred approach.

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The cognitive behavioural approach may have apparent advantages of being time limited and structured with the paper exercises giving a sense of 'work in progress' and something tangible to 'show' for the time spent with the counsellor. It is not always the appropriate therapy for a child. Certain difficulties may require a longer and less structured approach particularly where feelings are not attached to inappropriate or irrational beliefs.

Similarly child-centred therapy is not suited to all childhood difficulties. Certain children may find talking to a therapist anathema and welcome a more familiar encounter with activities to focus on and questions to lead them into participation. This type of counselling favours the child presenting material for consideration without direction. A more open ended time scale is needed to allow the client to progress at her own pace. It is not always possible to have unlimited time for one child, for example, in the school setting where the case load may be large, the child may be missing classes or moving on to further education elsewhere. Schools may also not favour an individualistic ideal where the child is encouraged to look at herself rather than consider her role as part of a community.

"*The practitioner in school must balance the wish to find the client's self with the need to survive and thrive in the competitive culture of modern education and peer-group pressure*...."
(Lines, D., *Brief Counselling in School* 2002)

Difficulties for the child-centred practitioner may lie in areas of transference and in the ability to express empathy or see the world as a child does.

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John, aged 11 years, expressed his knowledge of the practice of 'egging' new first years at the local secondary school, which he was due to attend in a few months. His therapist assumed that he was afraid of this happening, failing to recognise that, for this child, 'egging' was a right of passage and carried a significant element of excitement. For the therapist it held only personal anxiety being a 'cultural' practice out with her own experience.

Self-regulated practice with clients referred by their GPs allows for longer working time-scales.
Stella's case, as outlined earlier, would not have leant itself to having a time limit imposed on it. After two years Stella continues to be supported by infrequent but regular counselling to allow her to re-visit some of her issues.

A cognitive approach could have been successful in challenging some of her fantasies; it would probably not have addressed the underlying self esteem and support issues in this case.

It would also have been inappropriate to use a cognitive approach for Tim who was 10 years old when his mother died. She had been his sole carer. When she died he went to live with his father and step-mother who lived locally. They seemed to have difficulty in empathising with Tim and expected him to fit in with their life style immediately and continue to progress well at school. They became angry when his school work suffered and, as appearances were important to them, chastised him for making any mess in their house of cream upholstery. Tim's cognitions appeared to be rational; he

was grieving, disempowered and unhappy enough to state that he wished he was dead. Allowing him to speak about his plight in safety, taking him seriously and fully acknowledging his sadness and sense of injustice, seemed to help him to accept his feelings about his circumstances as being reasonable. This process was enabling him to achieve congruence between feelings and circumstance. In turn he gained the confidence to use his extended family network, in particular a fond grandfather and school teacher for support.

Cognitive behavioural therapy also has draw backs in that it is not certain at what age a child's cognitions are well enough established to make the process valuable. Cognitive development reaches a concrete operational stage between the ages of about 7 to 12 years. The younger the child the less secure the value of the interventions.

"*Although CBT has been used with young children, those under the age of 9 years have been found to benefit less than older children.*"
(Stallard, P., *Think Good-Feel Good,* 2005, ch.2 p.15)

Marie aged 5 years was stealing food at school. There was much insecurity for her at home including a history of sexual abuse. All gentle attempts at addressing the problem of stealing was met with shame and tears but the stealing continued. It was difficult to assess the depth of understanding she had of her behaviour but she engaged readily with non directive play therapy where she did not speak directly of her actions but played at her dogs at home stealing. Questioning and instruction prior to the child-centred work had shown little evidence of increasing Marie's ability to reflect on her behaviour.

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"*The degree to which young children have the required level of cognitive maturity to be able 'to think about thinking' has been the subject of debate."*
(Stallard, P., *Think Good-Feel Good,* 2005, ch.2 p.15)

In Marie's case it was useful to be in the school setting in order to liaise easily with school staff and her mother, full permission having been given for this.

Cognitive therapy can, however, offer practical interventions which the child can use outside the therapy room. Some exercises help to identify the underlying or 'hot' thoughts that have triggered unhelpful behaviour, challenges to 'blaming behaviour', negative and self-deprecating thoughts and promotion of self-affirming strategies designed to raise the young person's morale in the face of self-doubt.
Adolescents are more likely than younger children to understand and use these more academic and sophisticated ideas.

Morag, aged 15 years, amongst other issues, had worries about her mental health. She had heard of people who had obsessive compulsive disorder but had only superficial knowledge of this illness. She was performing a ritual of closing doors at home in sequence before leaving the house, sometimes returning twice to check. The tenor of her day was contingent upon this ritual. "My friend will be a pain or won't speak to me or something if I don't shut the doors!" When asked if there was any link between her behaviour and her supposed outcome Morag could immediately identify the lack of logic in this ritual. She was asked to rate the strength of her belief and then set a task to

find a way of testing the belief. She felt she would be taking a risk by omitting the ritual on one day but one that was worth taking because her friend sometimes did not speak to her even when the ritual was followed. Her prediction failed to materialise on completing the test and, although she felt the need to use the test again, quite quickly she could identify the 'magical' thinking and was reassured that she did not suffer from a mental illness. For this aspect of Morag's behaviour a positive result from the counselling could be seen and, if necessary, checked.

The two models of counselling have distinctly separate uses in different settings but equally may be useful in a combined approach with one child's difficulties. Comparisons exist in the basic therapeutic conditions, which they offer to a child or young person and the basic premise that the client will benefit from personal insights into their emotional and behavioural responses to their environment. They both regard the therapist as a person accompanying the child on a trail of personal self-discovery.

Contrasts lie in the types of interventions used and the structure of the therapy. Non- directive child-centred encounters using reflective listening, with the focus on challenging the child to acknowledge and explore feelings. Cognitive behavioural therapy, directive and academic, gives scope for understanding and on-going challenge to faulty belief systems which result in dysfunctional behaviour and unhappiness. At times the more time limited and academic style of cognitive behavioural therapy may have more appeal when working within certain agencies with less time resources, greater audit requirements and with older children as the client base. The exploration of underlying feelings of the child-

centred approach makes it a valuable resource for children who are younger, less cognitively mature, or more traumatised by events.
The validity of either approach within any setting should be assessed by the counsellor and the aims of the counselling kept clearly in mind. Inappropriate counselling interventions will disaffect the young person from the process both at the time and possibly for the future.

"*The literature demonstrates that there is no one preferred way of working which is appropriate for all children.*" Geldard and Geldard note that they have found in their own work that "…*effective work with children depends on selecting a method of working which is specifically suitable for a particular child and relevant for that child's issues."* (Geldard,K., & Geldard,D., '*Counselling Children A Practical Introduction*' , 2001 p34)

Young people who encounter and respond to the stresses of life sometimes need help to make sense of the events, the feelings and themselves. Appropriate therapeutic intervention may help them to achieve this.

"How can you get very far,
If you don't know Who You Are?
How can you do what you ought,
If you don't know What you've Got?
And if you don't know Which To Do
Of all the things in front of you,
Then what you'll have when you are through
Is just a mess without a clue
Of all the best that can come true
If you know What and Which and Who."
(Hoff, B., *The Tao of Pooh,* 1982 p58)

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