Expanding therapy: Challenging the dominant discourse of individual therapy when working with vulnerable children and young people. A discussion paper

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This paper seeks to challenge the powerful and growing discourse that individual, face-to-face therapy is best and only way for clinical psychologist to help children with mental health and emotional needs. We propose that it is timely to re-challenge narratives of what is therapeutic and argue that taking a broader definition of therapy is vital if we are to continue to help the most vulnerable and complex cohorts of children and young people.

> 'Of course they need individual therapy – they have a mental health problem!'
>
> Does this sound familiar?

Working with young people with complex presenting problems within a CAMHS setting, we have often received referrals and reports from social workers, care staff and other mental health professionals, asking (demanding) that a young person receives 'individual therapy'. The referrals might specify 'cognitive-behavioural', 'attachment focused' or 'relationship-based' alongside their recommendations, or indeed 'long-term', but rarely do they comment on their expectations in terms of what might change for the client were this therapeutic work to be undertaken. For example, a recent report regarding a client with a complex history concluded (without further clarification):

> While [client A] does not [have] any mental illness, they would benefit from individual therapy to address their early attachment and trauma history'. Furthermore, when these 'requests' for therapy are challenged or questioned, usually because it is not what the young person wants or needs, there is a sense that we are being unhelpful. We suspect this is familiar to many of us.

From our experiences of working with young people within the youth justice and looked after systems, many of these 'recommendations' are made in the context of young people experiencing numerous placement breakdowns, with little or no meaningful attachments. Almost universally the young people have complex and often traumatic attachment experiences. Some may also have additional experiences of neglect, violence, emotional, physical or sexual abuse. The reports that often come with the referred child or young person bring, tacitly or overtly, strong pressure from the court, social workers and care staff that direct, one-to-one therapy is the only solution, without clear goals around likely outcomes. In addition, commissioning of CAMHS services and service level agreements for these 'complex needs' populations in some areas seem to have become driven by the need to get young people 'into individual therapy' as soon as possible, with seemingly little evidence to support this approach as effective on its own with this population. Indeed, there is a growing body of opinion that appears contrary to this view:

> Too narrow a focus on individual therapy can lead to an expectation that children will adjust to a world for which they are not equipped.

> The therapy becomes a way of 'making children fit' (Golding, 2006, p.306).

We feel strongly that we need to review and challenge this dominant discourse of individual therapy if we are to truly guide and shape services for children and young people in a positive direction. This paper begins to set out some of our thinking and takes the position that the best interventions are grounded in solid formulations with clear goals and aims that fit with wants, as well as the needs, of the client and involve a creative application of sound scientific psychological knowledge.

Misplaced therapy – therapy without the system

When trying to justify our time providing psychological consultation to care staff or foster carers, we are often heard muttering the mantra 'but you *are* the therapy'. Is it not arrogant to believe that one or two hours a week spent with a young person is the primary facilitator of change, when they have spent the other 166 hours with other people? Without a focus on what happens in the rest of a young person's life, therapy can become an irrelevance, or at worst a contributor to further disruption.

A recent case example illuminated this for us, where advice from the clinical psychologist involved was given to the 'system' that individual therapy was not indicated as the placement was not deemed secure enough, and the relationships not secure enough, to help the young person regulate the emotional demands of the therapy process. However, psychological consultation was offered for the care team to promote caregiver sensitivity and help develop more secure relationships within the placement. Against this advice, an 'attachment therapist' was employed independently by the residential care provider in agreement with the placing authority, as the young person 'was ready for therapy' and 'we can't just do nothing'. Within three sessions the young person was in crisis and the care giving system had all but broken down, resulting in a move into secure accommodation. Unfortunately, in our experience this is an all too frequent scenario. We have heard many anecdotal examples of young people being 'given therapy', only to develop more severe difficulties as a result. If individual therapy is applied without meaning to the wider context in a young person's life it can be an exhausting, off-putting process, and at worst damaging. It is unsurprising that such therapeutic relationships do not connect with the young person's wider context as, by their very nature, they are ambiguous and ill defined, and therefore remain separate. On the 'other side', professionals and caregivers wait expectantly for change as a result of the therapy, with little notion of the central role that they can themselves play in the therapy process.

Ussher (1991) describes, how by marking groups out as different 'outsider groups' we can affirm a position of normality, or even ascertain what that is. Ussher advocates that it is this boundary between normal and abnormal that helps to maintain society. In childhood, the youth justice and children looked after systems can be viewed as such 'outsider' groups, distinct from 'normal' childhood constructions, whom it is assumed are not rejected and do not commit crimes. Always positioned as 'Other' (mad and/or bad), both these outsider groups may serve the purpose of protecting the boundary around 'normal' childhood. In addition, we suggest, this provides protection for adults as caregivers in a caregiving system, particularly if these 'outsider' children's problems are viewed as reversible through individual therapy. This position can lead caregivers to feel disempowered as key figures in solution finding and as agents of change. It can also lead the 'expert' in therapy to feel frustrated and seek increasingly complex understandings within the limited framework of positivistic psychology, when the therapy is not working.

Of course, we are not suggesting that all individual therapy is unhelpful, but we are suggesting that we take care to ensure that care systems carefully consider the huge potential for the negative impact of therapy and do not just assume the 'default' position of therapy, as it is the easiest (or cheapest)

option and justifies that we are doing 'something'. In fact, doing 'nothing', in terms of individual therapy, might be better in certain circumstances!

Well-placed therapy – widening the lens

So what are the ingredients of good therapy for young people? Before addressing children and young people with complex needs, a starting point might be to reflect on some of the things we believe about working therapeutically with children generally:

- Children and young people rarely refer themselves to mental health services, so initial contact is usually due to an anxiety in some part of the system.
- It is useful at the assessment stage to involve as many people as are thought necessary by the child/young person and family/system to help to think about the problem, as well as hearing about levels of resilience, so that any intervention is agreed by the system (the referring entity) as well as the child, to achieve best outcomes.
- Children and adolescents can generally experience (and report) that 'just' talking one-to-one with an adult in a room can be experienced as intrusive, anxiety provoking and unhelpful.

There is a growing movement advocating that putting the 'family' or system back into child and adolescent mental health services is a helpful service provision for children and young people. The National CAMHS review (Department for Children, Schools & Families, 2008) recommends purposeful assessments at early stages of problem identification to facilitate clearer interventions. Recent developments in service delivery such as the Choice and Partnership Approach (CAPA), neatly encompass these current views (see Mental Health Foundation, 2009, for a review and evaluation of the model). CAPA models collaboration with the system rather than expertise over and above the system's perspective, creating a joint contract for working therapeutically that can be shared by all members of the system rather than just prescribed to the child. This is true for all CAMHS work, but seems particularly relevant when working with vulnerable young people.

Vulnerable children and young people

The National CAMHS review recommends that vulnerable children should have access to the full range of service provision rather than have their needs met outside mainstream provision by specialists alone. This, together with the call for a thousand more child therapists to improve access to psychological therapies for children by Lord Layard (2008), creates a fantastic opportunity to reconfigure services.

When the right therapy, and right person, is matched with the client's needs and wishes, at a time and in a place when they are able to tolerate the emotional demands this requires and the added pressure on their attachment system, the results can be powerful and positive. Our argument is that this environment does not (and cannot) only exist in one-to-one therapy in a clinic setting. Therapeutic opportunities can come to light over a game of football (or 10), a game of cards or a visit to the local shops – in the hour-by-hour, daily interactions with the people who care for young people. As long as such 'moments' of therapeutic interaction are derived from a scientific formulation, grounded in a sound evidence base and the impact checked and refined (Taylor, 2008), it is still therapeutic; just applied in a non-traditional setting, in which it may be easier to reach a 'hard to reach' client. For such groups, is this not likely to be therapy at its best?

Sadly, the environmental conditions for 'therapy' are rarely met for young people with complex presentations, particularly within the criminal justice or looked after system. Too often foster carers, residential staff and social workers are unsupported in both their understanding of the treatment rationale, access to supervision and emotional support, and availability of practical things like time for reflection. However, we do witness the process of 'therapeutic interactions', as described above, numerous times between young people and their carers, but almost universally underestimating their potential

impact on the young person. They can resist the notion that even just by sitting with the young person they may be being therapeutic. When we try to encourage this type of approach with groups of staff, we are often met with the (perhaps defensive) response 'but we are not therapists, you are supposed to do this!'

We argue that therapy for young people, and particularly those with complex presentations, needs to be seen within the context of their attachment systems first. From an attachment perspective, it would seem sensible to assume that any meaningful interaction that activates the attachment system can potentially be therapeutic, and can also potentially be harmful. This has been shown to be particularly relevant for adults with complex presentations (Bartels & Zeki, 2004; Fonagy & Bateman, 2006a, 2006b) and it seems sensible to assume that young people with adaptive but 'problematic' attachment models are also likely to be particularly sensitive to these processes.

Clearly, within a caregiving relationship, this process takes on a huge importance. Therefore, a consideration of attachments and relationships both within and outside of any individual therapy is crucial to any formulation and subsequent intervention plan. Whilst CBT may be considered attractive by the care-giving system in a bid to change a symptom, it denies the system the opportunity to understand, work with, and stay with what is difficult – the attachment patterns underpinning the symptom. The modality or 'technique' used is secondary to the quality of the relational systems the young person is confronted with. Therefore, we believe we need to broaden the definition of what therapy is.

What can psychologists do?

Within CAMHS, clinical psychologists are well placed – maybe uniquely placed – to promote an overarching therapeutic approach based on prompting system changes and improving the quality of interactions. The core of our training is to develop sound formulations; to apply a wide range of valid psychological knowledge and theory, flexibly and creatively, and to build a rational understanding of the difficulties our clients present with. From these formulations, along with the client's wishes and goals, comes an understanding of the therapeutic task. We can then select from, or advise on, the possible, evidence-based ways of completing the task – there is rarely just one way – and individual therapy is even more rarely the one.

Clinical psychologists are in many instances best placed to provide part of the intervention, and even more often best placed to provide the system with a clear understanding of the problem and on the ways of intervening – what ever the interaction with the young person might be – how to bring individual therapy into everyday interaction so to speak. So, is it time to involve ourselves more in the everyday therapeutic process and demonstrate how we can help to add value to the role that psychology can play in the community?

Clinical psychologists can help promote the conceptual changes in what is currently understood by therapy in the following ways:

Use of language

The language that we use can make the notion of what we mean by 'therapy' ambiguous. This adds to confusion and an overreliance and overexpectation on individual therapy with a 'specialist' in its traditional form. Some clarification of the language we use to describe therapy and to distinguish what is 'therapy' from what is 'therapeutic' would be useful. Furthermore, we think we need to rebalance in people's minds the relationship between 'therapy' (which is all too often seen in isolation as the answer) and 'therapeutic' day-to-day living. We need to be clear that individual 'therapy' is not the primary tool for positive change: it is the day-to-day experience of the young person. It is the young person's daily interaction with the world (and more importantly other people), not that in the therapy room, that should be viewed as the primary therapy. That is why carers and the relational systems these young people find themselves in are so important.

How we use language in assessment, formulation and intervention plans can keep

the system at a distance or include them as primary facilitators of change. The use of language in the CAPA model adequately demonstrates how the system around a child can engage in a partnership and can take responsibility for system shift (York & Kingsbury, 2005)

Consultation and training to the system: Supporting others to be therapeutic is a core factor

Including the system in a clear formulation, then devising collaboratively a systemic intervention can help the system with ownership of alternative futures, this could be input on systemic adaptations to the current context or advice on broader contextual changes: a change of placement or educational setting. Offering training and support through adequate regular supervision and reflection is central if we are to train those around the young person to guide therapeutic interactions.

Outcomes not input

Well-meaning therapists can often be coerced by the systems and service drivers such as 'number of face-to-face contacts', to engage in traditional therapy with young people. In adapting our formulations (and expressing them well and with confidence through the language we use) to include the system as primary facilitators of change, commissioners, referrers, carers and clients may understand more clearly why we sometimes refuse their requests for 'individual therapy' or at least delay them. Whilst pleading with commissioners not to configure services for young people with complex needs with 'number of face-to-face contacts' as a primary indicator of success, we recognise how we, as psychologists, need to think more about what we can do to help this shift.

Thankfully there is a shift away from how much we do (input) to how well we do it (outcomes – e.g. CAMHS Outcomes Research Consortium; see www.corc.uk.net and NICE Guidelines), but there is still work to be done here – not least in finding measures that really capture the complexity of the work we do well, and what we do badly. Rarely do we read papers that say, 'we tried this approach but actually it went horribly wrong'! Is the reluctance in reporting these in our outcome measuring, preferring to put the deterioration down to 'other factors', helpful? If we are not reporting these outcomes, how can we provide a balanced argument for commissioners and others that actually services should not be created based on how much therapy they deliver?

Conclusion

Let us be clear: we are not purporting to be peddling any radical new therapy here, nor do we see this as breaking new ground. What we are saying is that traditional one-to-one therapies are often not sufficient or at least do not fit so well with some of the more disturbed children and young people that we see. If we are to be helpful to this vulnerable group of children and young people then we need to think creatively about how we can translate formulations and interventions into everyday therapeutic interactions that optimise the possibility of sustainable change in their lives. We also need more focus on the system around the child, and intervention with staff needs to be considered to be a valuable and crucial component of the intervention package.

So why are we saying this now? Well, for one, the discourse of individual therapy is worth questioning at any time, but it feels as though the discourse is becoming overly and unhelpfully driven by court process, NICE and the powerful Improving Access to Psychological Therapies (IAPT). which perpetuates the idea that individual is always best. Whilst we are not proposing an end to traditional individual therapy for children and young people (far from it), we are suggesting a much more balanced approach to its use, particularly with complex presentations. We urge IAPT, when considering service provision for children and young people, not to mimic its approach with the adult working age population but instead to seriously consider a more holistic, system view, otherwise vulnerable children will become more vulnerable still. We feel there is a growing need for a wider debate around this within clinical

psychology and the world of mental health and well-being more generally. We would welcome this debate.

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