

Southern Cross University ePublications@SCU

Centre for Children and Young People

2014

Supporting children through difficult times: recognising, responding and referring

Mary Ann Powell
Southern Cross University

Publication details

Powell, M 2014, 'Supporting children through difficult times: recognising, responding and referring', *Centre for Children and Young People: Background Briefing Series*, no. 10.
© 2014 Centre for Children and Young People, Southern Cross University, Lismore, NSW Australia

ePublications@SCU is an electronic repository administered by Southern Cross University Library. Its goal is to capture and preserve the intellectual output of Southern Cross University authors and researchers, and to increase visibility and impact through open access to researchers around the world. For further information please contact epubs@scu.edu.au.

Centre for Children
and Young People



research, education & advocacy

Supporting children through difficult times: Recognising, responding and referring

Centre for Children and Young People
Background Briefing Series, no.10



Dr Mary Ann Powell

for Southern Cross University's postgraduate programs in
Childhood and Youth Studies

This Background Briefing has been developed as part of the Graduate Certificate, Graduate Diploma and Master of Childhood and Youth Studies developed and delivered by the School of Education and the Centre for Children and Young People at Southern Cross University.

These awards meet a recognised need, expressed by a range of professionals, for contemporary knowledge and skills to assist them to work more effectively with children, young people and their families.

This and other Background Briefing Papers, together with more information about these awards, can be accessed at www.scu.edu.au/childhoodstudies



SUGGESTED CITATION

Powell, M. (2014). *Supporting children through difficult times: Recognising, responding and referring*. Centre for Children and Young People Background Briefing Series, no.10. Lismore: Centre for Children and Young People, Southern Cross University.

Supporting children through difficult times: Recognising, responding and referring

Introduction	1
Section 1 - Recognising why and when children need support in difficult times	2
1.1 Perspectives on emotional problems and issues.....	3
1.2 Causes of emotional distress for children and young people.....	4
1.3 Broader contexts of child development	6
1.4 Theories relevant to understanding children’s emotional needs.....	10
Section 2 - Responding to children’s need for support through difficult times	15
2.1 Where children turn for support	15
2.2 The role of ‘front line’ professionals.....	16
2.3 Awareness of specialised roles and services.....	17
2.4 What children want in terms of support	18
2.5 Skills for effective responding.....	18
2.6 Responding to concerning disclosures from children.....	23
2.7 The importance of reflective practice.....	24
2.8 Self-care: Maintaining boundaries and avoiding burnout	25
Section 3 - Referring children and young people for support	25
3.1 Differentiating between emotional support, mental health and child protection issues	25
3.2 Brief overview of services and service models	26
3.3 Counselling.....	28
3.4 Other therapeutic modalities.....	31
3.5 Critical issues in referring children and families to specialised services.....	35
Conclusion	39
References	40

About the author

Mary Ann is a Postdoctoral Fellow with the Centre for Children and Young People. Her research interests include ethics in research with children and young people, children's social and emotional wellbeing, and rural childhood. Mary Ann's professional background is in child psychotherapy and, prior to developing her interest in participatory research with children, she worked in a range of practice contexts in New Zealand, predominantly with children and families who have experienced family violence, abuse, neglect and trauma. Currently she is involved with an international research ethics project (ERIC) and an Australian Research Council (ARC) funded project focused on improving approaches to wellbeing in schools. Mary Ann has also been involved in postgraduate teaching and supervision in New Zealand in the field of child psychotherapy and child mental health.



For further details and a list of Mary Ann's publications visit

http://works.bepress.com/maryann_powell/

Inviting your Critical Engagement

Photos used throughout this publication are sourced from Shutterstock (<http://www.shutterstock.com>). They have been selected to highlight the diversity of ways in which children and childhood can be represented.

We encourage you to engage critically with these images as you reflect on the idea that 'childhood' is socially constructed. Ask yourself, 'What message about children or childhood is being conveyed through this image'? 'How do these images challenge my understandings of children and childhood'?



Introduction

From time to time, people working or spending time with children and young people feel concerned about a particular child. Their concern may be brought about by something that is said by the child or by others, a change in the behaviour of the child or knowing something of their circumstances. At such times it can be difficult to know what to do.

The situations and possibilities that can arise when working in a frontline capacity with children and young people are endless. These could include children:

- grieving the loss of someone close to them through death, separation, illness or relocation;
- adjusting to changed family circumstances;
- dealing with the consequences of a traumatic experience, such as a car accident or natural disaster;
- living in situations of emotional, physical, sexual abuse or neglect;
- families affected by adverse economic conditions and poverty;
- experiencing frightening symptoms of mental illness; and
- coping with bullying, loneliness and poor esteem.

Sometimes the path to be taken to support the child is clear. More often, the need for support is evident, but the appropriate course of action is less so. Or there can be glimpses or hints that things are

difficult for the child, but the actual cause of concern is not easily identified. The situation can be further complicated by not knowing what options are available, or what they involve.

There is no simple recipe for supporting children through difficult times and knowing how to respond can be very anxiety provoking. Concerns about doing the wrong thing and exacerbating the difficulties for the child, their family or others are equally matched by concerns about the potential consequences of not doing anything. In short, knowing what to do, or when and how to do it, is not easy.

Working with children and young people in a range of community-based capacities, I came across situations in which it seemed clear that children were asking for, or needing, some kind of support. The scope and magnitude of this varied. Although it sometimes felt as though I was alone in those situations, I became increasingly aware, as I gained experience working as a child psychotherapist (in clinical, supervisory and teaching capacities), that struggling with how best to support children through difficult times was not an uncommon experience.

This Background Briefing paper is not intended to equip you with counselling, therapeutic or assessment skills. Rather it aims to provide frameworks for understanding and assisting children and young people, including supporting them to gain any professional help they may need.

In providing such frameworks and discussing contexts for supporting children, I am keenly aware that the “map is not the territory” (Korzybski, 1933). Theories and abstractions of ideas provide guidance, but can only go so far in helping with reality itself. What is most important is that you have an awareness and understanding of these ‘maps’, how they relate to your own personal and professional experiences and individual circumstances, and how they might help guide decisions you make.

To be able to support children through difficult times, people working with children need to be able to identify that there is something going on for the child and that some kind of support would be helpful (**recognise**). They need to engage with the child in a way that will enable them to feel supported or take up any further support (**respond**), and they need to know where and how such support might be available and accessed (**refer**). This Background Briefing is thus structured around these “three R’s” – Recognise, Respond and Refer.

Section 1 - Recognising why and when children need support in difficult times

To be able to support children and young people effectively it is essential that ‘frontline’ professionals can recognise when children might need or want that support. At the outset, this seems a relatively obvious and simple statement. However, enacting it successfully involves having particular knowledge and skills across a range of areas, as well as the capacity to integrate information from a range of sources, manage one’s own self and role, and think reflexively.

People working with children in any capacity are usually doing so within a particular role or specific area of expertise. They might, for example, be teachers, social workers, nurses or youth workers. They will not have the expertise, time or inclination to provide assessments across the range of areas and sectors that might be needed, for example mental health, care and protection and therapeutic assessments. However, it is incredibly helpful if they can recognise when such assessments may need to be done and have the knowledge, skills and abilities to support the child in accessing such an assessment. Equally important is being able to recognise when such assessments and interventions are *not* necessary and the child’s need for support might be better met closer to home.

Across the many varied contexts in which children’s lives are led:

*...children have a quite extraordinary capacity for coping, problem solving, decision-making and goal setting... Given **timely and appropriate support**, children are capable of reconstructing their experience in ways that enhance agency (a sense of being enabled and so acting upon what they can influence) as distinct from dependency (being constrained by acting upon decisions, processes or family dynamics they can’t or don’t wish to influence) (Graham, 2011, p.15, emphasis added).*

Recognising when a child might need emotional support and what would constitute *timely and appropriate support* requires some understanding of what might constitute a difficult time for children and the potential causes of emotional distress.



1.1 Perspectives on emotional problems and issues

The way in which children's emotional concerns, or need for support, are viewed impact on the approach taken and the kind of support the child is likely to be offered. The meaning attributed, and weight given, to perceived causal factors or particular behaviour vary in different contexts, as does individual's threshold of concern. For example, while there is considerable crossover, the behaviours that might generate concern that a child is 'at-risk' can differ across school, mental health and family/home contexts and opinions as to the origins of causal factors might also differ (Gross & Capuzzi, 2008). Furthermore, viewing children as being 'at risk' is not universally accepted. Approaches to student mental health have shifted over the last decade from those heavily circumscribed by discourses of 'risk' and 'harm' to an increasing emphasis on resilience and strengths-based discourses (Graham & Fitzgerald, 2011).

*The literature on resilience provides an alternative view that sees youth **at promise** rather than **at risk**, and offers counselors, teachers and parents [and others] positive and viable resources for promoting the wellbeing of youth (Lewis, 2008, p.39, emphasis added).*

The different ways in which professionals might view emotional issues experienced by young people give rise to different ways of responding. Mental health professionals sometimes classify symptoms into categories, focusing on the problem and how this is resolved, whereas school/education professionals often define the problem in terms of associated behaviours and focus on responding to these behaviours (Prever, 2010).

The medical model

The medical model focuses on assessment, diagnosis and treatment, and is the dominant view of unhappiness in Western societies (Prever, 2010). This is primarily a problem-focused, deficit model, emphasising factors related to psychopathology, maladaptive functioning and symptom resolution. This model tends to see emotional issues as 'problems' that require fixing and, accordingly, 'experts' are required to identify and name the problem (Prever, 2010). This approach has an important place and highlights the critical role of assessment in relation to the emotional wellbeing and mental health of children and young people. However, it can leave children and families feeling isolated, individualised and pathologised (Downey, 2009).

Placing mental illness in perspective with respect to psychosocial problems, and defining mental health more broadly, is a preferential approach to promote social and emotional development and learning (Urbis, 2011).

Strengths based approaches

Over recent years, there has been a shift in research and service delivery from the more deficit, medical model, to a strengths-based approach, highlighting the individual's strengths, resources, skills, competencies and networks that may enable positive adaptive functioning and outcomes (Hunter, 2012; Sharry, 2004). A strengths-based approach is, in part, practical application of resilience theory (Hunter, 2012). Resilience theory moves beyond identifying risk factors, to including protective factors that may help lessen some of the negative influences of adversity.



Awareness of specific risks and protective factors occurring in a child’s life “allows practitioners to target their practice to reduce the risks and boost relevant protective factors in order to offer the child the best chance of experiencing positive outcomes” (Hunter, 2012, p. 9). Resilience-led perspectives and strengths-based approaches have become “a platform for progressing a range of initiatives aimed at improving children’s social and emotional wellbeing” (Graham, 2011, p. 12).

1.2 Causes of emotional distress for children and young people

Emotional upset and distress can come about from a wide range of causes, which may not always be clearly apparent. What affects one child may not affect another child, or may affect them differently, depending on their life experiences, relationships and view of the world.

Issues of concern to children and young people

Recent research conducted in Australia helps us to identify what concerns there may be for young people. A large scale national survey of 45,916 young people aged 11-24 years (Mission Australia, 2011), revealed the following issues as of greatest personal concern:

School or study problems	37.3%
Coping with stress	35.4%
Body image	33.1%
Family conflict	28.1%
Bullying/emotional abuse	22.8%
Personal safety	20.3%
Depression	18.1%
The environment	17.7%
Drugs	16.9%
Alcohol	15.2%
Suicide	9.9%
Discrimination	8.8%
Physical and sexual abuse	8.5%
Self harm	6.4%
Sexuality	6.45%



The ranking of these concerns differs across age groups. The top three concerns for 11-14 years olds were: school or study problems, body image, and family conflict equal with bullying/emotional abuse. The top three concerns for 15-19 year olds were: coping with stress, school or study problems, and body image. The top three concerns for 20-24 year olds were with coping with stress, body image, and depression.

The research also indicates a differing emphasis on issues according to gender. The most prevalent concerns for girls were body image, coping with stress and school/study problems. Whereas, the main concerns for boys were school or study problems, coping with stress and family conflict.

The Mission Australia surveys include children aged from 11 years. Research documenting the concerns for younger children is very limited. However, a recent NZ study of children aged mostly 8-10 years identified 29 stressors, the majority of which cluster around the family and school contexts (Pienaar, 2010). Many of these are linked to the stress experienced by the significant adults in children’s lives, mainly their parents. Pienaar identified changing sources in children’s concerns over the last four decades, from the problems identified in the 1970s and 1980s by children including family issues, friends and peer pressure, to the inclusion in the 1990s of issues as bullying, being hurt, stranger danger, disasters and being touched inappropriately. More recently, bigger global issues like terrorism and global warming have also been identified as issues of concern.

Issues identified in the international literature

International epidemiological research provides us with another framework for thinking about the emotional concerns children and young people may experience. Based on recent reports, the most common disorders in children and adolescents described as having mental health problems are as follows:

- **anxiety disorders**, including Generalised Anxiety Disorder and Social Anxiety Disorder, with girls tending to have more of all subtypes of anxiety disorders;
- **behaviour disorders**, including Attention Deficit and Hyperactivity Disorder (ADHD), Conduct Disorders and Oppositional Defiant Disorder, with prevalence higher in boys than girls for all types except oppositional defiant disorder;
- **mood disorders**, including depressive disorder and bipolar disorders, often associated with other disorders such as anxiety and conduct disorders;
- **substance use disorders** (alcohol and other drugs), with inconsistent indicators of gender differences (some studies showing equal prevalence rates, others showing that males have greater rates than females).

(Drawn from Urbis, 2011, p.22)

It is important to remember that the above review, pointing to major areas of concern related to health, and in particular mental health, approaches children's emotional, social and behavioural issues

using a medical lens. As a cautionary note, Adelman and Taylor (2006, cited in Urbis, 2011) contend that more and more children and young people who are manifesting emotional upset, misbehaviour, and learning problems are routinely assigned psychiatric labels which:

...flies in the face of the reality that the problems of most youngsters are not rooted in internal pathology, and many troubling symptoms would not develop if environmental circumstances were appropriately different (p.23).

The same problems viewed through a different lens may receive different labelling. In addition to this, inconsistent trends in psychological and emotional distress and mental health can be attributed, in part, to changes in the way mental health problems are measured, and the varying methodologies used by researchers (Urbis, 2011).

Psychological and emotional distress in school-aged children is often described in the literature through reference to the concepts of 'internalising' and 'externalising' problems or behaviours (Urbis, 2011). Generally, studies point to gender differences. For example, a literature review concerning the impact of exposure to domestic violence on the wellbeing of children and young people found that boys externalised problems more frequently (exhibiting behaviours such as hostility and aggression), while girls exhibit more internalised difficulties (such as depression and somatic complaints) (Holt, Buckley & Whelan, 2008). These authors acknowledge that some studies have not found significant gender differences.



Externalising behaviour refers to ‘acting out’ of problems through behaviour that is aggressive, disruptive or violent. Bullying behaviour is a subset of the larger construct of antisocial-aggressive behaviours and is defined as including repetition, intent to harm, and a power imbalance (Urbis, 2011, p.22). Internalising behaviours include disorders such as depression, anxiety and suicidal ideation, and are generally not as easily identified as externalising behaviours.

While anxiety and depression can be diagnosed as mental health disorders they do not have to be at a clinically diagnosable level for them to be an issue for children and young people. Suicidal ideation has been reported in up to 20% of all high school students and “as the single leading cause of death among adolescent young people below 15 years of age in Australia, China, New Zealand, Ireland and Sweden” (Urbis, 2011, p.24).

It is not clear from the literature whether there has been an increase in psychological and emotional distress and mental health problems in recent years. It has been suggested that, rather than saying the psychological and emotional distress and mental health problems of children and young people are currently more prevalent than they were in previous decades, it could be argued that they are more extreme (at both the positive and negative ends of the continuum) now than they were before (Urbis, 2011). Also, perhaps, they receive more focus and attention than in the past. This would explain why some studies have shown an increase in positive features such as self-esteem and happiness, as well as an increase in negative features such as mental health problems.

Another approach to understanding the causes of emotional upset and distress in children and young people is through identification of stressors. A number of stressors have been identified that potentially impact on children and young people. Potential causes of stress may include factors brought about through a range of life events, including: natural disasters; child abuse; family changes, including parental separation; economic stress; school-related stress; sexual identity; developmental changes; and interpersonal stress. However, it is difficult to determine causality in relation to certain emotional or behavioural outcomes. Experiences of stress are determined in



multiple ways by personality and contextual factors, which are further compounded by developmental changes and individual responses (Rheineck & Miars, 2008).

Certain family or home situations may also flag potential difficulties for children. Literature indicates that children may experience particular difficulties in certain contexts, for example, if living with domestic violence (Holt et al., 2008), parents who misuse drugs or alcohol, or parents with mental illness (Diggins, 2011). Children and families in these and other circumstances may have complex needs. Not all will need support but those that do may find it difficult to access help.

1.3 Broader contexts of child development

As well as being influenced by the way in which emotional issues are perceived, the support that children are offered or receive is influenced by other contextual factors, including the way in which children and their development are viewed, and the contexts in which children live their lives and engage with others. One important way of considering children’s need for emotional support is through a developmental lens. Such an approach acknowledges that issues of concern to children are likely to change over time and, importantly, that different events and experiences impact on children in different ways and can affect their subsequent development and experiences.

Maturational perspectives

The traditional child developmental theories (such as those by Piaget) take a *maturational perspective* in which development:

is founded on the child's genetically influenced characteristics, unfolds according to maturational timetables, and moves forward through a series of tasks and challenges of increasing complexity that the child must master in order to extend her ability to function within herself and within her environment (Davies, 2011, p.3).

From this perspective the course of development is fairly predictable and inevitable.

This perspective is helpful in accounting for the different capacities that children have for action and understanding at different ages, which may be explained, to some extent, by differences in hereditary gene expression. However, such differences can be explained to a greater extent by “how the developmental capacities have been shaped in the history of the children’s transactions with multiple environmental contexts” (Davies, 2011, p.4).

The importance of maturational child development theory, in relation to supporting children who are experiencing difficult times, is that it helps us understand typical development and, consequently, development under adversity (Downey, 2007). As such it raises awareness of behaviours that might indicate difficulties which, in turn, allows for greater sensitivity in relation to these. If we know the

behavior typically expected at different ages, it will flag potential concerns if we see behavior usually associated with another age. As Kegerreis (2006, p.410) describes, “what would be worryingly conformist in an adolescent would be more normal in an 8-year-old. What would be acceptable in an 8-year-old might be considered worryingly obsessive in an adolescent”.

Developmental theory also helps us to understand how children might manifest their upset or distress, and to understand the influence age has on the child’s ability to understand and process their experience (Holt et al., 2008). In the case of traumatic experience, for example, an older child may be able to understand and rationalise more easily the cause of the trauma, whereas a younger child may find this more difficult, inaccurately apportioning blame or claiming responsibility for things outside of their control.

Child developmental theories alone do not account for the important differences that are often seen between children of the same age. Further, they have been criticised for being normative and privileging particular world contexts, namely the minority (‘western’) world. Children who do not match these developmental norms are perceived in terms of deficit.

An alternative view of children’s development incorporates interaction with, and the influence of, environmental factors. The transactional, interactional, and ecological models of development (described below) represent such contrasting perspectives.





Transactional perspectives

A *transactional model of development* suggests that development is a product of continuous dynamic interactions between the child and the experience provided by his or her family and social context (Davies, 2011). It includes consideration of the individual qualities of the child, parental and familial factors, and social/environmental factors. It incorporates interactions and sociocultural aspects in the environment.

From this perspective, the child's transactions with the environment create alternative pathways that development proceeds along. At critical points, such as times of developmental change or external influence, junctures appear in the developmental path and the child may move off that path and onto a different one, in adaptive or maladaptive directions (Davies, 2011).

The transactional model also recognises that the child works to organise his or her experience. Rather than being a passive recipient of experiences, "the child actively creates his or her own environment, increasingly so with advancing development" (Davies, 2011, p. 4).

The transactional perspective is particularly helpful for understanding development in relation to trauma and adversity. It provides a perspective in which children's behaviour can be understood in the light of their experience. As such, much of what may seem to be 'difficult' behavior can be re-interpreted as stemming from adaptive responses

to difficult experiences. It also highlights that interactions with the environment, which are dynamic, fluid and ongoing, can have a significant influence on children's development and behavior. This opens up opportunities for supportive, positive experience.

Ecological perspectives

The transactional perspective is compatible with Bronfenbrenner's *ecological model of child development* which emphasises the importance of the dynamic environmental contexts in which children and young people develop (Hamilton & Redmond, 2010). This ecological model suggests that human development takes place through "interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate external environment" (Bronfenbrenner & Morris, 2006, p.797).

The child's or young person's ecological environment consists of a series of nested structures of environmental influence. At first children interact primarily within their *microsystems*, which usually consist of family members. As children get older their social sphere increases to include, for example, childcare, kindergarten, school and friendship groups, referred to as the *mesosystem*, and interactions within these groups become more important. The *exosystem* refers to the broader social context in which the child and their family lives. It includes the social networks and places within the wider

community that have a more indirect influence on the child or young person through their influence on the microsystem, for example, parents' workplaces and service centres. Finally, the *macrosystem* refers to the wider society, including social norms and values and economic conditions.

These structures are dynamic and change through time, so that as children grow older their microsystems shift, for example, away from dependency on parents and towards friendship groups (Hamilton & Redmond, 2010, p.17)

Viewed from an ecological perspective, there is an ever-widening circle of influence on children's development. For younger children interactions are mediated by their parents and the quality of the parenting, which in turn is shaped by the interactions parents have and the influences on them. This has important ramifications for supporting children through difficult times. Younger children are less likely to have extensive avenues of support, and are likely to find support that is inclusive of, or mediated by, their parents helpful. This can therefore be fraught if the difficulties experienced by children are directly related to their parents or their parents are unable to provide the kind of support that is most wanted.

Over time, opportunities and stressors in children's lives are less directly mediated by their parents and their interactions with the environment are increasingly independent of them. As children get

older their interaction with the environment becomes more complex and the number of people they interact with expands, through school and/or community based experiences. However, parental support is still an important correlate of adolescent social and emotional wellbeing (Hamilton & Redmond, 2010).

To understand the child's perspective, to get a sense of how they are experiencing difficult times and what they might need, we need to listen to what they have to tell us. The onus thus lies with the adult to actively engage with children in order to elicit their views (Hamilton & Redmond, 2010).

Synthesis and compatibility of perspectives

In summary, the transactional and ecological perspectives accommodate a broad range of interactions and experiences. They integrate the genetic component of development with the influences of experiences and interactions that subsequently shape the child's development. These perspectives thus take into account differing sociocultural contexts, family and community environments and also have the capacity to incorporate children's own participation in shaping their childhood. They are thus highly relevant when recognising and responding to children's need for emotional support, as discussed in the following section.



1.4 Theories relevant to understanding children's emotional needs

Drawing on theoretical understandings of the contexts in which children live, experience, develop and grow, helps in recognising when children might need or want support. In particular, theories of attachment, trauma and resilience provide the underpinnings for understanding children's emotional concerns and contexts of support. For example, if children have had some kind of difficult experience or life event, integrating theories of development, attachment, trauma and resilience help us understand the complex world they are experiencing.

Attachment theory

Attachment theory helps us understand human relationship development from pre-birth onwards throughout the life span. Developed by John Bowlby, the theory centres on the early parent-child relationship as a critically important influence on subsequent development. The underlying premise is that an infant is born with innate proximity seeking behaviours. Caregivers respond to these behaviours and, through a repetitious cycle of seeking-responding, an attachment relationship is developed between the infant and primary caregiver. Attachment theory was developed further by Mary Ainsworth, who elaborated the main categories of attachment - secure and insecure. Insecure attachment is further organised into the main categories of avoidance, ambivalent and disorganised.

Evidence from empirical studies overwhelmingly indicates that quality of attachment is a fundamental mediator of development (Davies, 2011). Essentially, the nature of the attachment relationship depends on the quality of the care experienced, and ongoing development in terms of social and emotional functioning is influenced by the quality of the attachment.

Universal features of attachment include: a baby needs to have an attachment to a primary (or set of primary) caregiver(s); a hierarchy of attachment allows for attachment relationships with more than one person; and consistency, sensitivity and



contingent responding on the part of the primary caregivers are essential to the baby's psychological development. Different values and practices of caregiving influence the expression of attachment behaviour across cultures. Cross-cultural studies identify variations in attachment behaviour and caregiving practices, but attachment itself is a human phenomenon across cultures (Davies, 2011).

Over time, the child gradually internalises an understanding of relationships, developing what is known as an internal working model of self, and self in relationship to others, based on the primary attachment relationship(s). This becomes stabilised, providing the child with expectations regarding how relationships work, and a sense of their own self in relationships (Davies, 2011). Attachment theory "asserts that the development of self as a socio-emotional being is mediated by relationships with other people" (Daniel, Wassell, Ennis, Gilligan & Ennis, 1997, p. 212).

Attachment theory is thus important for recognising when children need support. It can provide important cues for understanding children's social behavior in relationship to others, including very young children whose behaviour may provide more cues than their verbalisations.



Understanding that early attachment relationships affect functioning in later relationships, including those with people in supportive roles, helps us recognise that some children may find it difficult to form relationships and access the help they need during difficult times. They may have expectations that such help will not be forthcoming, or may be at too great a risk or cost. It helps us identify why some children may be struggling socially and understand some of their difficulties. Such understanding brings empathy, patience and compassion, which is an intervention in and of itself (Downey, 2007).

Trauma theory

Trauma theory helps us understand the psychological and neurobiological impact of traumatic experiences (for example abuse and neglect) on the human individual (Downey, 2007). There are numerous definitions of trauma and a wide range of events that may be considered traumatic for children. The common theme across these is that particular events render the individual helpless (Atwool, 2000).

Terr (1991) offers a definition of trauma in relation to children and young people, as: “the mental result of one sudden, external blow or series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations” (p. 11). Terr also differentiates two types of trauma. Type I trauma are one-off paroxysmal, unexpected events (for example, a car accident) while Type II trauma are repetitive, although often unpredictable (for example, sexual abuse or living in a war zone).

Following Type I trauma children are likely to return to usual functioning more easily (following intervention if necessary) depending on their previous developmental context. Traumas giving rise to adverse psychological outcomes include natural disasters such as earthquakes, hurricanes and (in the Australian context) bushfires (McDermott, 2004). The psychological outcomes can include fear, depression, self-blame, guilt, loss of interest in school and other activities, regressive behavior, sleep and appetite disturbance, night terrors, aggressiveness, poor concentration, and separation anxiety. “Symptoms vary from minimum to severe based on a child’s developmental level, personal experiences, emotional or physical health, and the responses of parents to the incident” (Baggerly & Exum, 2008, p. 80).

Type II trauma, however, can be associated with more entrenched emotional, social and behavioural difficulties, and require referral for more intensive or long term professional intervention to help alleviate these. With Type II trauma the impact of the original trauma, or detrimental experiences such as neglect and deprivation, can be further compounded by subsequent traumatic experiences.

A diagnosis of post-traumatic stress disorder (PTSD) may be made. This is a more severe emotional consequence of trauma, with diagnosis being made on the basis of symptom clusters in the areas of: re-experiencing symptoms (for example, recurrent, intrusive recollections of events); persistence avoidance of stimuli associated with the trauma; and persistent symptoms of increased arousal (for example, hypervigilance or an exaggerated startle response).

Repeated experience of trauma, such as severe abuse or neglect, at an early age can compromise brain development (Perry, 1997). Brain cells or neurons organise in groups that carry out particular functions and these become interconnected through brain circuitry. “Genetics provides the template and timetable for this process, whereas experience shapes the particular ways a child’s brain responds to the world” (Davies, 2011, p.39). Chronic unmediated exposure to stress, such as abuse or neglect, is an ongoing experience that has significant effects on brain development in young children, leading to the development of stress response systems. These physiological response patterns (for example activation of the ‘fight or flight’ response) become entrenched over time, and form part of the child’s ongoing behaviour.

Trauma theory, as with attachment theory, is important for recognising when children might need support. It provides a theoretical context for understanding the impact of events on children’s lives at different stages on their developmental pathway. It also indicates that children’s behaviour can give indications of, and help frontline people understand, children’s emotional responses to difficult times. Such understandings enable people to provide support in a contextually appropriate and meaningful way.

Resilience theory

The shift to a strengths-based approach has led to a rise in research on resilience (Hunter, 2012). Resilience has been defined in a number of ways, however most definitions agree that resilience necessarily involves two elements – an exposure to risk, adversity or traumatic circumstances and successful, adaptive functioning following this exposure (Hunter, 2012; Trussell, 2008).

Adversity can be seen as a precursor to resilience in that children need to have adapted to some form of adversity in order to develop resilience. Resilience is not a fixed or static attribute but rather one that may change over time, in accordance with development and subsequent experiences (Urbis, 2011). Resilience can be seen as a continuum of possibilities, which is based on the balance of risk and protective factors across development, interacting with stressors or opportunities at particular points in time (Davies, 2011).

A key theme in understanding resilience is the interplay between risk and protective factors (Trussell, 2008). These factors emerge from the broader transactional contexts of children’s lives, including the individual qualities of the child, parental and familial factors (in addition to attachment), and social/environmental factors (Davis, 2011). Essentially, risk factors heighten the probability that children will experience poor outcomes, while protective factors increase the likelihood of a positive outcome and help promote resilience (Urbis, 2011). There does not appear to be a single path to resilience, and “both risk and protective factors may have different impacts on children at different stages of development” (Hunter, 2012, p.2).

The interplay of different risk and protective factors, across different developmental stages, may help account for the individual differences in people’s responses to the same experiences. If practitioners can make sense of these components of resilience then they can work to enhance it by reducing exposure to risk and increasing exposure to protective factors (Hunter, 2012).



A range of risk factors have been identified, including:

- biological risks impacting on the central nervous system and development;
- psychological risks, including personality characteristics associated with poor outcomes;
- family risks, including conflict and overcrowding;
- risks pertaining to school;
- community risks, including conditions and influences that create hostile environments; and
- stressful life events (Urbis, 2011).

Research indicates that children can experience a range of stressful events with varied responses and can show great resilience in the face of these (Jones, Gutman & Platt, 2013). The child's age at the time of the stressful event can be a factor influencing wellbeing in relation to some, but not all, events. Events such as parental divorce, parents arguing, moving house and attending a new school, for example, are associated with worse wellbeing when the event occurs for children under seven years of age.

Importantly for people supporting children through difficult times, Linke and Radich (2010) draw attention to myths of resilience. They argue that children are not born resilient and they don't automatically bounce back. What happens in the early years can change who they are (Perry, 1997). While some children may appear resilient, they may not necessarily be. Research suggests resilience may be domain specific, with children able to function competently in some areas of their lives (despite signs of being highly traumatised), but not others (Hunter, 2012).

Not all children who have had traumatic experiences go on to experience difficulties. Protective factors "mitigate risk by reducing stress, providing opportunities for growth, or strengthening coping capacities" (Davies, 2011, p.60). Such protective factors include:

an even temperament that elicits positive responses from others; an affectionate relationship with a significant adult; an external support system which provides a sense of belonging and fosters confidence; an overall disposition to set goals and actively participate in decisions regarding her/his life and future; an average intelligence; a history of effective parenting; areas of talent or accomplishments; and socio-economic advantages (Urbis, 2011, p.19).





Secure attachment with at least one adult is seen as one of the most common protective factors found in resilient children, which clearly has implications if the child has experienced trauma related to the loss of the key attachment figure (Hunter, 2012).

Although quality of parenting is the most important mediator of risk, other relationships can be protective for children (Davis, 2011). These might include relationships with a number of relevant professionals, such as sympathetic, empathic and vigilant teachers; a champion who acts vigorously on behalf of the child; or a mentor or trusted adult with whom the child can discuss sensitive issues (Rose & Aldgate, 2000). Although, it is important to bear in mind that that it is the more resilient child who is most likely to be able to illicit the help they need from adults.

An ongoing positive relationship with a non-parental adult promotes resilience even when parenting ability is impaired (Davis, 2011). For children growing up with a severely mentally ill parent, for example, which includes children of 15% of parents in Australia (Australian Institute of Health and Welfare, 2012), warm relationships with other adults, either in or outside the family, contribute to more adaptive functioning. Supportive grandparents are a particularly potent protective

factor. Research also indicates that, amongst other things, children of parents with mental health problems want “someone to talk to – not necessarily formal counselling” (Diggins, 2011).

The importance of resilience theory for supporting children in difficult times lies in both recognising that children have different responses to adversity and trauma and in offering a perspective when responding that emphasises protective factors and children’s strengths. Resilience theory thus underlies a strengths based approach which can assist frontline support people to find positive and proactive means of supporting children and strengthening self-esteem.

Children are not just victims of experience, they can also be resilient authors of experience... What is striking, and inspiring, is the extent to which we find that children facing all kinds of adversity – even young children – bring energy, ideas, understanding, capacity of their own, to bear on the problems they face. As adults who aspire to help children and young people, we must avoid shortchanging children in terms of not appreciating what they can bring to the table when issues in their lives are being faced and addressed (Gilligan, 2005, p.8).

Section 2 - Responding to children's need for support through difficult times

Having discussed frameworks for recognising and understanding contexts in which children and young people might need support through difficult times, this section looks at how people might respond. First it considers the roles of support people, then turns to areas of skill development for supporting children.

As discussed in the previous section, there is rarely a direct causal pathway leading to a particular outcome. Therefore, it is seldom clear what the 'best' response is. The range of factors and variables, stressors and strengths, which interact at particular times in children's lives lead to a vast range of possibilities. Each child is unique and their reactions to difficult times will vary in accordance with (amongst other things) the nature of the difficult time or events, age, gender, personality, socio-economic position, role within the family, as well as relationships with parents and siblings and available supports. Even when it seems clear that certain factors may impact in particular ways, these do not occur in isolation and do not necessarily take into account children's role in constructing their own social world. Consequently, responses and interventions need to be timely, appropriate and individually tailored to build on the resilient blocks in the child's life (Holt et al., 2008).

2.1 Where children turn for support

There are a range of sources available for support that can be accessed by children and young people who have concerns or are experiencing difficult times.

A recent Australian survey found that the three main sources of support and advice for young people aged 11 to 24 years of age, across all issues of concern, were *friends*, *parents* and *relative/family friends* (Mission Australia, 2011). Use of the internet has increased rapidly over recent years and was ranked highly as a source of advice and support for over 20 per cent of respondents, particularly concerning sexuality, the environment, discrimination, body image, depression, and self harm. In an even more recent

survey the internet was nominated as the primary source of information for over 75 per cent of young people aged from 15 to 19 years (Mission Australia, 2012). Other sources referred to included teachers, school counsellors, community agencies, someone else in the community, magazines and telephone hotlines. However, worryingly, over 20 per cent of respondents felt they did not have anywhere to go for advice and support about their number one issue of concern.

The Mission Australia survey raises a number of issues. What, for instance, happens for the over 20 per cent of young people who do not have anywhere to go for support and advice? Where do children under the age of 11 years turn for support? With one of the main sources of support being parents, how is this support affected in times of family conflict? How can specialists and support services effectively connect online with children and young people? And what is the potential of the internet as a resource for support and advice for young Australians living in regional, rural and remote areas where there is less access to support services?





Parents are a key source of support for children, as indicated in the Mission Australia surveys. *Responsive parenting* was identified in a recent study in the Netherlands as a core theme in promoting the psychological recovery of children after single-incident trauma (Alisic, Boeije, Jongmans & Kleber, 2012). The study described *responsive parenting* as consisting of being aware of a child's needs and acting on these needs. The paper outlines strategies used by parents to estimate the seriousness of posttraumatic stress reactions, and also strategies to assist children. "Central to responsivity were parents' attempts to follow their children's pace while providing structure and guidance when necessary or seeking help to do this" (Alisic et al., 2012, p.279). However, it can be challenging for parents to respond sensitively and in a way that is optimal for supporting children. Sometimes, their capacity to be responsive is negatively influenced by their own level of well-being or distress.

Research indicates that a relationship with a caring, supportive adult can be a protective resource for children going through difficult times (Holt et al., 2008). In reviewing literature concerning the impact of domestic violence, Holt and colleagues found the availability of someone for the child to turn to for emotional support was considered crucial, emphasising the key role of the wider social and community support structures and supportive relationships more generally.

2.2 The role of 'front line' professionals

People who children and young people turn to for support may already have a specific role in relation to them. The nature of their response and their capacity to respond will therefore often be determined and/or circumscribed to an extent by this role. Conflicts can arise for the child as they may not be able to relate to the adult in the way they wish across different contexts and, also, problems may arise for the adult as different roles require different kinds of relating (Prever, 2010).

Dual roles and boundaries

It is therefore important that people in support roles are clear as to the boundaries of their role. If time is being offered specifically to talk with, and listen to, a child then the parameters of this need to be clearly defined and mutually understood (Prever, 2010). "You cannot make yourself available to a particular child or young person all of the time" (Prever, 2010, p.38).

Boundaries are the clearly established limits that allow for safe connections between individuals. They help safeguard both the adult and the child, and allow for a clear understanding of the limits and responsibilities of the roles. Boundaries might include, for example, being friendly, *not friends*.

Boundaries are important for a range of reasons: staying focused on one's responsibilities; providing helpful and appropriate support; avoiding *rescuing* (rather than supporting); role modelling healthy communication in the context of an appropriate



relationship; avoiding burn-out (or “compassion fatigue”) and vicarious traumatising; maintaining safety; and working collaboratively (as appropriate) in a healthy and open way with other professionals and family members (Wolf & Krebs, 2008).

The determining and maintaining of boundaries, and clarity around dual roles, can be assisted by professional codes of conduct or ethics. Many adults working with children are bound to these codes through membership of a professional body or employment requirements. An important premise underlying ethical codes is that adherents should not practice outside their area of expertise.

Establishing and maintaining healthy boundaries can be assisted by being clear with the child regarding your role, your availability and the best ways to communicate with you. Training and ongoing supervision can play an important role in supporting and maintaining appropriate boundaries. An aspect of boundaries is managing any self disclosure. One stance on this is to not disclose any personal information about yourself at all. Another stance is, if you do decide to tell a child something personal about yourself, that you ensure that the information is related to the goals of the supportive relationship (Wolf & Krebs, 2008).

An important boundary issue that can arise when working with children and young people is concerned with confidentiality and the limits of this

(Prever, 2010). Prever points out that children have very little confidentiality in their lives, with information flowing relatively freely between parents and teachers, or health professionals and social workers. Consequently, if a child entrusts an adult with a confidence there might be a hope and expectation that it will remain confidential, offset by previous experience of this not being the case. Maintaining confidentiality is an important aspect of building trust in relationships. There do need to be major limits to confidentiality in the light of care and protection concerns (as discussed further on in the Referring section). However, much of what children might share with an adult does not need to be passed on.

2.3 Awareness of specialised roles and services

For children to be supported by a wide range of people can only be a good thing. However, it is important that people are clear on the parameters of their role and that there are openings for communication between professionals. Referring children to appropriate professionals and services is discussed in greater detail in the following section (Referring). However, it is worth flagging here that being aware that certain issues require specialist support is critically important.

Some areas of concern require particular expertise and specialised training, knowledge and professional affiliation. Children who are suicidal or self harming, those with severe mental health issues, or who have experienced abuse, trauma or neglect, for example, may be well *supported* by non-specialists but require the expertise of a specialist to help with those concerns. Even within professional disciplines there are calls for specialisation. In the psychotherapy profession, for example, Oz (2010) calls for the recognition of childhood sexual abuse as a specialised field, requiring specialised training at both graduate and postgraduate levels.

Many professions require registration at a state or national level. In addition, there are professional bodies, which require a certain level of training, qualification and/or practice to gain membership. Professional body membership provides assurance that the individual has practice standards and ethical accountability. Counselling and psychotherapy are not regulated professions in Australia, as they are in some other countries.

Consequently, Schofield (2008) contends that there is a perception that therapists are inadequately trained and supervised. However, within the professional body Psychotherapy and Counselling Federation of Australia (PACFA) 59% hold postgraduate qualifications and 18% have specialist qualifications in child and adolescent therapy (Schofield, 2008).

These figures indicate that it is a relatively small proportion of counsellors and psychotherapists who have specific training in working therapeutically with children and young people. Those who work with adults have skills that may be helpful in working with children. However, in practice, additional, specialised skills, knowledge and understanding are required.

2.4 What children want in terms of support

For support to be effective it needs to come from the child's "frame of reference" (Prever, 2010), rather than representing an adult's interpretation of the child's perceived difficulties or what the adult professional or helper considers helpful or a solution.

In accordance with the spirit of the participation articles in the UNCRC, children and young people are increasingly being asked for their opinions on matters that affect them, including improving wellbeing outcomes. Children's views are then being used in some countries to inform practice and the development of policy (Murphy, Paton, Gulliver

& Fanslow, 2013). Consistent with suggestions emerging from research in trauma and resilience, for example, it is recommended that an adult who is external to the situation is available for children who have experienced difficult times to talk to. This underlines the important role played by people who are supporting children through difficult times.

Young people caring for parents with mental health problems, for example, want (amongst other things) someone to talk to, although not necessarily formal counselling (Diggins, 2011). A group of young carers in the UK came up with 10 messages as a simple checklist for practitioners who come into contact with families where a parent has mental health problems. The tenth item on the list was: "Tell us if there is anyone we can talk to. **MAYBE IT COULD BE YOU**" (Diggins, 2011, p.10).

In another example, recommendations from young people consulted in the course of developing a Scottish national domestic abuse policy include: "Ensure that every child in Scotland has access to a [named] support worker, to offer one-to-one support "someone they can trust and confide in" (Murphy et al., 2013, p. 9). Other recommendations included: training professionals to understand more about domestic abuse; improving access to outreach support in the community; making more help available in schools; and teaching teachers so they can understand and react better to children affected by domestic abuse.

2.5 Skills for effective responding

The skills required to respond to children and young people's needs are, in the first instance, effectively relationship and communication skills. If a child has chosen to talk to an adult about their concerns, it is safe to assume that there is a reason, or maybe several reasons, why they have selected this particular person. It may be that there is already an established rapport, that they trust the person, and/or that the person has some of the skills for effective responding already. These skills are not the domain of professionals, but rather characteristic of relationships which have respect for others as a core feature.





Establishing good relationships

The context for supporting children and young people is the relationship that exists or is formed between the supporting adult and the young person. It would be difficult to overstate the critical importance of this. In a range of professions involving children and families, such as social work, teaching and counselling, quality relationships are integral to successful practice (Gilligan, 1998; Prever, 2010). Indeed, in researching social workers' professional and emotional engagement with families in the UK, Leeson (2010, p.483) suggests that "quality relationships form the backbone of social work with children and their families". In the education sector, findings from a current research study at the Centre for Children and Young People on student wellbeing point to a quite overwhelming consensus about the importance of relationships in the context of wellbeing in schools (Graham et al., 2013, in progress).

Skills for effective responding, including counselling skills, exist within the context of relationships. Within the counselling profession, relationships take pre-eminence over technique (Prever, 2010). McLeod (2008) argues that counselling skills alone are not enough and focusing on these does not do justice to what might be achieved, and can result in overlooking crucial relationship dimensions. These dimensions are: the moral or ethical aspect, whereby the counsellor has the capacity to create a space in which the client feels affirmed and accepted; the relationship that develops; and the capacity for reflection and self-awareness of the counsellor.

The relationships within which support for children occurs is not confined to specialists. McLeod (2008) argues that counselling is *embedded* within other professional roles and tasks. As noted, specialist professionals and services have a critical role to play in particular spheres, for example, mental health, and this will be discussed further in relation to referring children and young people appropriately. However, offering and providing support is not confined to these relationships.

Help comes in many forms, it doesn't just come in white coats or by formal appointment. Therapy does not occur only in clinical settings. Just as everyday life often provides the physiotherapy that people may need when striving to recover normal physical functioning after serious injuries and operations, so everyday life often contains many opportunities for psychotherapy for children striving to recover normal psychological functioning after serious trauma and hurt. Ordinary everyday living contains many positive opportunities for healing, often mundane, unexpected or unrecognised. It is often the little things that carers, teachers or others do that make a difference (Gilligan, 2005, p.10).

"Clearly, establishing a relationship with a young person in need is a central prerequisite to any kind of helping alliance" (Prever, 2010, p.68). This involves treating each child as an individual and taking them as they come, recognising that children and young people are not a homogenous group and should not be treated with developmental uniformity or in accordance with treatment manuals (Campbell & Simmonds, 2011). A useful approach to supporting children is a person-centred approach, which emphasises the person and the therapeutic nature of human understanding, rather

than the role the person plays. Taking this approach centres on the quality of the relationship and the psychological climate, rather than the adult “doing things” to a child (Prever, 2010).

In addition, forming relationships is not only relevant when the child has concerns – it is not contingent on her or him experiencing difficulties. Relationships are organic and ongoing, and an existing relationship can provide the impetus for children to turn to an adult for support. “It’s how we handle the ‘ordinary, everyday small stuff’ that lays the groundwork for handling the ‘big stuff’” (Faber & Mazlish, 2005, p.57).

Key elements are integrity and authenticity in relationships. Research on therapists’ perspectives on the therapeutic alliance with children and young people found that the ability of young people to detect insincerity and trustworthiness in a therapist (described as ‘having their own radar’) “highlights the importance of therapist sincerity, honesty and authenticity in developing trust” (Campbell & Simmonds, 2011, p. 205).

Dealing with feelings and emotions

Communicating effectively with children requires specific skills, which are different (or in addition) to those required when communicating with adults. While it is the child’s perspective on their own concerns or problems that is most important, the responsibility to establish effective communication lies with the potentially supportive adult (Rose & Aldgate, 2000). In addition, communicating with children who are emotionally distressed or concerned requires particular skills and personal qualities.

Sometimes it can be difficult to sit with the unpleasant feelings a child might have. It is hard to listen to children and young people express confusion, resentment, disappointment and discouragement and to see them unhappy. Consequently, and with the best of intentions, adults can dismiss children’s feelings and impose adult logic to show them the ‘right’ way to feel (Faber & Mazlish, 2005) or make them ‘feel better’. Not accepting children’s feelings and trying to subtly steer them away from unpleasant sensations, may have more to do with the adult’s comfort than the child’s (Prever, 2010).

In order to support children, their feelings need to be acknowledged. If feelings, such as distress, are dismissed, minimised or negated, adults may unwittingly be adding to the child’s unhappiness or distress. Similarly, children and young people are not always looking for advice. Rather than dismissing feelings or giving advice adults can respond empathically to help young people feel understood and free them up to focus on what they need to do (Faber & Mazlish, 2005). Such empathic responding includes identifying, acknowledging and accepting feelings.

Listening can give the greatest comfort and acceptance of unhappy feelings can make it easier for children to cope with them (Faber & Mazlish, 2005).

If the child who has been exposed to trauma is to have a voice we need to be prepared to listen. There is ample evidence that adults are not good at this... if our strategies of intervention are to be child focused they must provide opportunities for the child to communicate (Atwool, 2000, p.26).

Listening contributes to getting to know each child as an individual. *Active listening*, according to Geldard and Geldard (2008), is a way of letting children know that we are willing to enter into their world and to respect their view of that world. These authors outline four major components to active listening: matching body language; the use of minimal responses; the use of reflection; and the use of summarising.



Asking questions and using feedback statements can be ways to “help a child get more fully in touch with their emotional and hopefully release them” (Geldard & Geldard, 2008, p.117). However, it is critically important to be mindful of not encouraging children to release feelings in contexts which are potentially unsafe. For example, the supportive adult may not be sufficiently skilled or the child’s environment may not be such that they are able to safely support children’s uncontained feelings if they are particularly intense. If a child becomes distressed in talking with an adult, the responsibility lies with the adult to be able to provide sufficient emotional containment,¹ and reassurance, for the child to continue safely.

As well as listening to what children have to say, we need to seek to understand what the child is telling us through his or her behavior (Gilligan, 2005). In other words, we need to listen to their words *and* their behavior.

Establishing rapport and maintaining positive relationships

Rapport is defined as “a close and harmonious relationship in which the people or groups concerned understand each other’s feelings or ideas and communicate well” (Oxford Dictionary, 2013). It is based on mutual respect, confidence and acceptance. Establishing rapport is an important foundation to positive relationships, enabling children to feel confident in communicating and being supported.



¹ In this context, containment refers to the capacity of one person to be alongside another with the confidence, presence and skill necessary to emotionally manage the distress of the other person so that that he or she is not overwhelmed by their own distressing feelings.

There are a number of ways to enhance the establishment of rapport, including active listening, being aware of eye contact and body language, using age appropriate communication styles and language, being neutral and non-intimidating, and working to minimise power imbalances. Developing rapport has particular challenges and requires skills in adapting to children at different ages. At the core of rapport with all ages, however, is respect for the child and building trust.

Person-centred counselling practice, as developed by Carl Rogers, provides a useful framework for considering the establishment of safe, trusting relationships. The core conditions, underpinning relationships aimed at therapeutic growth and change in person-centred practice, are those of unconditional positive regard, congruence and empathy.

Unconditional positive regard is an attitude that involves showing complete support and acceptance of a person, no matter what that person says or does. With unconditional positive regard the child feels accepted, valued and worthwhile.

This may be difficult to achieve in supporting children for a number of reasons, not least of which are the attitudes regarding children and childhood that are held by the adult.

We are used to advising our own children and sometimes even telling them off ‘for their own good’. We bring to our relationships our own upbringing and values which may become more conservative with age. Our attitudes to childhood and adolescence are influenced by media images and contemporary concerns about the behaviour of young people. Being judgmental, one could argue, comes naturally and certainly more easily than offering the kinds of attitudes and communications suggested by Rogers (Prever, 2010, p.89).

The importance of congruence and empathy have already been discussed in relation to attachment and trauma. Children have the ability to detect insincerity and trustworthiness. Empathy provides a connective tissue between the adult and the child (Campbell & Simmonds, 2011). Focusing on connection and relationships (rather than a more medical model of symptom resolution) “places us firmly in the social world and reduces the tendency to isolate, individualise and pathologise traumatised children and their families” (Downey, 2009, p.7).



Building self-esteem and promoting resilience

Building self-esteem and promoting resilience happens within the context of supportive relationships. A resilience based perspective tends to be optimistic and pragmatic – believing that change is possible and may come through supportive relationships and new ways of thinking about problems and possibilities (Gilligan, 2009). This involves a deliberate step away from professional preoccupation with deficits and pathology. A relationship with a committed adult may be what tilts the balance for a child. Relatively small incidents can make a big difference and can represent turning points in children’s lives.

A key message from the resilience perspective is helping the young person to “hang on to and build on positive factors, threads and niches in their lives” (Gilligan, 2009). This may help unearth and release some fresh and unrecognised resources in a child’s daily life and natural social networks. Positive school experiences and spare time activities can have enormous value as protective factors. “One thing going well may change a child’s perception of themselves, and what is possible” (Gilligan, 2005, p.9).

Promoting resilience in the context of trauma requires all adults to have an understanding of the impact of trauma and be willing to consider the possibility that challenging behavior from children may indicate they have experienced, or be experiencing, trauma (Atwool, 2000). Atwool argues that the traumatised child may be ‘invisible’ and their voices not heard. Their visibility depends on adults being aware of what has happened or is happening, understanding that children’s reactions

to this vary and may not be what the adult would expect. Seeming to be coping is not the same as coping. Seeking the child’s views and perspectives on their experience is critical. It is also essential to pay careful attention to observing what may be going on for children, as adaptive behaviour and defences may mask underlying fears and anxieties.

A number of strategies have been identified to assist parents, professionals and others engaged with supporting children who have experienced trauma (see for example, Alisic et al., 2012; Downey 2007, 2009; Lazarus, Jimerson & Brock, 2003; Perry, 2002; and the Better Health Channel fact sheets from the State of Victoria, 2012). Key features of these include being calm and reassuring, being consistent, acknowledging children’s feelings, having predictable routines, being comforting, not being afraid to talk about the traumatic event, promoting positive problem solving skills, emphasising resiliency, and being aware of post-traumatic symptoms.

Following traumatic experiences, such as natural disasters, most children show typical signs that can be mitigated by teachers, parents and others providing emotional support. However, for some children this may not be enough and they may experience ongoing symptoms that disrupt their daily functioning and require professional support such as counselling (Baggerly & Exum, 2008) or referral to Child and Adolescent Mental Health Services (CAMHS). For example, McDermott, Lee, and Judd (2005) found that 22.6% of children in their Australian study had abnormally high emotional symptom six months after exposure to a wildfire disaster.



In some contexts psycho-education can be helpful for building self-esteem, with worksheets one mode of facilitating this (see Geldard & Geldard, 2008 for examples). Psych-education can include social skills training, assertiveness, learning boundaries and can also assist children in learning protective behaviours.

2.6 Responding to concerning disclosures from children

There are some disclosures made by children that raise ‘red flags’ of concern and require an immediate and sensitive response. These are primarily related to safety, either of the child or another person, and include: disclosures of abuse, neglect or harm; suicidal thinking or attempts; self harm; or severe mental health issues, such as episodes of psychosis (for example, hallucinations, delusional thinking etc). Children’s disclosures of abuse are often not straightforward. They may be spontaneous, delayed, ambiguous, prompted by something quite different, and sometimes retracted.

The most important thing in the first instance is to respond sensitively to the child – by being calm, supportive and non-judgmental, letting them know that it is good that they have told you and that you will help them. This help will most likely involve contacting other people, usually through referral to the appropriate agency (for example, child and adolescent mental health services or child protection services). It is critical that the people who have been chosen by the child to disclose to

consult with others about the steps to take. This may be a supervisor, colleague, service/agency liaison person or helpline. “Disclosure is about seeking support and your response can have a great impact on the child or young person’s ability to seek further help and recover from the trauma” (Hunter, 2011, p.2).

In relation to sexual abuse, discovering or suspecting that a child has been abused can be distressing. People can feel a range of emotions including anger, sadness, shock, disbelief, disgust and helplessness (Victorian Government, 2006). It is important to stay calm since, if the child senses a horrified response, this may reinforce and perpetuate their feelings of guilt and shame, as well as preventing them from making further disclosures. Hunter (2011) emphasises that if a child discloses abuse, then there is a good chance they trust you. Simply by calmly and empathically listening and offering support you are helping the child or young person.

Suicidal thinking and self-harm is another area in which adults can feel anxious and unsure of how to respond. There are a number of myths and misperceptions associated with young people and suicide, and it can be difficult to know what to say or do. Myths include those around who is likely to attempt suicide, indicators, timing and methods (Capuzzi & Gross, 2008). For example, one of the most widely believed misperceptions is that young people who talk about suicide never attempt suicide. Capuzzi and Gross contend that adolescents make attempts (verbally or nonverbally) to let

people know that life seems too difficult to bear and these should always be taken seriously. They advise, “never assume such threats are only for the purpose of attracting attention or manipulating others. It is better to respond and enlist the aid of a professional than it is to risk a loss of life” (p. 253).

There are a range of verbal and behavioural cues that indicate young people may be suicidal. “A number of experts believe that about 90% of the adolescents who complete suicide (and lethal first attempts can result in completions) give cues to those around them in advance” (Capuzzi & Gross, 2008, p. 255). Any indications, particularly verbal cues, should be taken seriously and acted on by asking the young person for clarification, not making assumptions or minimising what is being said, and seeking further professional assistance.

There are a number of services that are available for children and these can also help support and guide you through the next steps. See, for example, the Australian Institute of Families Studies factsheet on helplines and telephone counselling services (AIFS, 2012a).

2.7 The importance of reflective practice

In order to achieve and maintain successful and meaningful relationships, people supporting children need to engage at an emotional as well as a professional level (Leeson, 2010). People’s sensitivity on a range of issues can vary on account of their own experiences. For example, people’s sensitivity to child abuse and reporting concerns can be influenced by their own past experiences of domestic violence or abuse (Kress, Adamson, Paylo, DeMarco & Bradley, 2012).

It is important to have the space and opportunity to examine and reflect on past experiences so that we are not unconsciously influenced by them, but have an awareness of the ways in which they may be impacting on us. Reflecting on one’s own life experiences and what has been helpful to this point (without becoming excessively self preoccupied and egocentric) can help when offering support to young people (Gilligan, 2004).

Supervision and mentoring can provide a useful context for reflecting on practice in relation to supporting children. For some professionals, such discussions will be already built in to their roles.

However for others, it may not be a formal requirement. Structuring time with appropriate colleagues for reflection and critical thinking about decisions made and situations encountered can provide support in decision making. It can also provide a forum for dealing with ‘emotional labour’ – which involves the management of feelings in accordance with the unwritten expectations of the employing organisation by either suppressing the emotions deemed undesirable or by inducing those that are expected or demanded (Leeson, 2010).

Time spent with a supervisor or mentor can also be useful to ensure that theory is not confused with ideology. Work with children and families has sometimes been subject to fashionable ideologies which may dictate the style of work adopted.

Ideological approaches, for example, ‘all children should be in family based care because residential care is bad for them’ or ‘siblings should be kept together at all costs’ should never get in the way of ethical and professional practice which discriminates effectively in relation to the developmental needs of a particular child (Social Care Group, 2000).



2.8 Self-care: Maintaining boundaries and avoiding burnout

It is important for people in a role that involves empathically supporting children and young people to insure that they are taking care of themselves. While empathy may provide the connective tissue in relationships, “the neurological, psychological and somatic mechanisms of empathy can lead to compassion fatigue or vicarious traumatisation” (Campbell & Simmonds, 2011, p.206). In supporting

young people we need to take care to not over-identify with them.

Taking care of yourself includes making sure that you are getting enough sleep, eating well, spending time with friends and family, exercising, seeking supervision and advice as needed, and “leaving work at work” to the greatest extent possible (Wolf & Krebs, 2008).

Section 3 - Referring children and young people for support

A key aspect of supporting children and young people going through difficult times is helping them get the particular type of support that will be most helpful. Some issues, situations or dilemmas are beyond the scope of the frontline support person and call for more specialised support. In these instances the frontline person can play a pivotal role in identifying the issue and facilitating a referral to an appropriate specialist or specialised agency or service.

This section looks at three areas in which referral may be helpful, depending on the situation: referral to counselling; to mental health services; and to child protection agencies. It looks at some of the issues involved in referral and focuses, in particular, on counselling, and the range of modalities that are offered.

3.1 Differentiating between emotional support, mental health and child protection issues

Clearly, it is not possible, or even desirable, for all adults working in ‘frontline’ positions with children to undertake assessments across the range that might be called for. Mental health and child protection assessments, for example, require specialised skills and training, as well as some level of institutional support. However, it is incredibly helpful for children, families, organisations and services if frontline workers are able to play a somewhat adapted variation of a *triage* role. The original meaning of the verb *triage* was “the action of sorting items according to quality”, but it was adapted in the 1930s, as a consequence of military use assessing the wounded on battlefields, to mean “decide the order of treatment of (patients or casualties)” (Oxford Dictionary, 2013).

In the context of supporting children, a form of *triage* can be seen to take place as those in a supporting role sort the nature of the concerns that the child or young person has, the appropriate services, agencies or support they should be referred to (for further assessment) and, at times, in which order this should occur. Sometimes there are multiple referrals that could be made. It is critically important that the support person is able to engage further support for the child or young person in





such a way that it is likely to be successful. This requires clear understanding of one's own role, and of this role in relation to the roles of others.

Having some idea of where, why and when to refer children and young people is critical to engaging the child or young person in the process. Children who have revealed something of themselves or disclosed something of concern have generally chosen a particular person to do this with and do not necessarily want to discuss the matter or take it further with anyone else, whether the someone else is a professional or not. It can take a huge amount of courage to reveal issues of concern or vulnerability, and the child or young person can perceive the referral as a form of rejection or feel anxious or intimidated at the idea of having to repeat talking about it with someone else. They can also be fearful of the consequences of talking 'more formally' with someone in any agency, regardless of whether the concern is related to their own emotional wellbeing, mental health or care and protection.

The support person needs to handle the situation very sensitively, with an awareness of how the child or young person may be interpreting the suggestion that further support is required. Part of this is having a degree of confidence (and understanding) about who or what the child is being referred to and what they might expect to happen in order to instill some confidence and overcome any fear or trepidation in engaging the child or young person.

Referral for specialised support does not necessarily diminish the need for ongoing support from others. Harris (1993, cited in Gilligan, 2005, p.8) provides a useful metaphor – "help may be more valuable coming in the form of a 'milk van' (low key, nurturing, regular, reliable, long term) rather than a 'fire brigade' (sudden, one-off, invasive, crisis driven, hyped)". For some children, in some situations, it may be that both are required.

3.2 Brief overview of services and service models

To help differentiate between children's need for emotional support and their need for referral for more intensive support it is important to know what services are potentially available. Following is a brief overview of mental health and child protection services, followed by a focus on counselling and other therapeutic modalities.

Mental health

All Australian states have specialised mental health services for children and young people. In most states these are referred to as Child and Adolescent Mental Health Services (CAMHS), although in Queensland they are referred to as Child and Youth Mental Health Service (CYMHS).

CAMHS provide specialist mental health care to children and young people with serious emotional, behavioural, social and/or psychiatric disturbances, together with assistance to their families. Generally, they see children from 0-18 years of age. They

usually are staffed by multi-disciplinary teams who see children and families on an out-patient basis. The teams may include psychologists, psychiatrists, paediatricians, child psychotherapists, social workers, family therapists, nurses and occupational therapists.

The kinds of concerns that are seen by CAMHS are those that can be classified as mental health disorders (for example those included in the DSM IV or ICD10), including depression, anxiety, autistic spectrum, suicidal or self harming behaviour, eating disorders, psychosis, trauma and severe family relationship difficulties. Children with Attention Deficit Hyperactivity Disorder (ADHD) may or may not be seen at CAMHS. Generally, referrals are made to CAMHS where the emotional, social or behavioural concerns are severe or complex, or at risk of becoming so, and where the child or young person's needs cannot be met elsewhere.

The CAMHS model developed in the UK, and used there and in Australia and New Zealand, envisages a four tiered system of professional involvement (Thompson, 2005):

- Tier 1 is the first line of service and consists of non-specialist primary care workers such as teachers, school nurses, general practitioners and social workers.
- Tier 2 consists of specialised primary mental health workers who take referrals and provide support to primary care colleagues, for example, educational psychologists, counsellors and clinical psychologists who offer assessment and services on issues such as parenting, behavioural concerns, bereavement, anger management, family work and so on.
- Tier 3 consists of multidisciplinary teams who work in clinics and specialised units, generally with issues too complicated to be dealt with at Tier 2, and have the capacity to offer individual psychotherapy, joint work and family therapy.
- Tier 4 consists of specialised day and inpatient units, where children and young people with more severe mental health issues can be catered for.

Despite this structure, there can be “considerable service variation, lack of models and consensus on which children and young people would benefit from specialist child and adolescent mental health services” (Rao, Ali & Vostanis, 2010, p.58), compounded by poor communication or lack of agreed care pathways between health and social services.

Care and protection

In Australia, statutory child protection is the responsibility of state and territory governments. Each state and territory has different legislation, policies and practices surrounding child protection but the broad processes are similar, and all have the aim of providing assistance to vulnerable children who are suspected of being abused, neglected or harmed, or whose parents are unable to provide adequate care or protection (Australian Institute of Health and Welfare, 2013). The relevant authorities and contact details for reporting abuse and neglect in each state and territory are available in a fact sheet collated by the Australian Institute of Family Studies, *Reporting abuse and neglect: State and Territory departments responsible for protecting children* (Australian Institute of Family Studies, 2012c).





Some groups of people are mandated (legally required) to report suspected cases of child abuse and neglect, however the specific reporting requirements vary between states and territories (see Australian Institute of Family Studies, 2012b). Mandatory reporting is considered to be a symbolic acknowledgement of the seriousness of child abuse, reinforcing the moral responsibility of community members to report suspected cases of child abuse and neglect, and aiming to overcome the reluctance of some professionals by imposing a public duty to report (Australian Institute of Family Studies, 2012b). However, as an unfortunate consequence of the increased public awareness and increased reporting of suspected child abuse that comes with mandatory reporting, existing resources are inadequate to meet the increased demand and some child protection departments have increased the threshold or level of seriousness of reports that give rise to an investigation.

Referrals to statutory child protection services are often referred to as *notifications*. Essentially, people are encouraged to make a notification if they have a reasonable belief that a child is being, or has been, abused. Proof is not required for notification. Rather, reasonable belief exists if a child tells you that they have been abused or displays some indicators for which there are no other satisfactory explanation (Victorian Government, 2006). The number of substantiated notifications (that is, notifications made to relevant authorities that were subsequently proven) in Australia increased between mid-2011 and mid-2012 (AIHW, 2013). The majority of notifications were made by police (24.6% of total notifications), followed by school personnel (15.1%).

By virtue of their long-term engagement with children, primary school teachers have, arguably, greatest opportunity of any professional to observe and act in response to CAN [child abuse and neglect] (Walsh et al., 2008, p.992).

Walsh and colleagues' Australian study found that teachers' decisions to notify child protection authorities involve a complex interplay of case, teacher and school factors, and underlines the importance of educating teachers about: "(a) the warning signs and indicators of different types of CAN; (b) the differential effects of CAN; (c) responding to child victims including responses to direct disclosures; and (d) accurate and timely reporting" (p. 983).

3.3 Counselling

There are a range of modalities that fall under the catch-all of counselling or psychotherapy. These include therapies with different theoretical frameworks as well as some therapies with similar theoretical underpinnings, but using different modes of communication or expression. In practice, therapists may have a strong theoretical perspective underpinning their work, but also draw on other theoretical strands and a range of methods when working with children and young people. The common characteristic across the theoretical frameworks is that they all involve a therapist and client (sometimes more than one) joining together in a relationship, with the shared aim of helping the client in some way.

A systematic literature review conducted by Pattison and Harris (2006), looking at a variety of counselling modalities (including cognitive-behavioural, psychoanalytic, humanistic and creative counselling approaches) across a range of issues (including behavioural and conduct disorders, emotional problems related to anxiety and depression, school related issues, self-harming practices and sexual abuse), showed counselling to be “a positive, useful and effective intervention for children and young people across the full range of issues” (p.112). However, research also indicates that counselling interventions tend to exclude children and young people with learning disabilities, despite evidence that “some counsellors are more inclusive than others, indicating the potential for inclusion” (Pattison, 2005, p.124).

Differences in counselling children and adults

A key issue in referring a child or young person to counselling or therapy is **who** to refer to. Counselling children is different to counselling adults (Geldard & Geldard, 2008) and counselling young people is different to counselling children or adults (Geldard & Geldard, 2010).

Specialised training is necessary for those counselling children and young people, as “working with children and adolescents demands a great deal that cannot be adequately provided in a course primarily geared to adult work” (Kegerreis, 2006, p.406). Kegerreis maintains that such training needs to include a thorough foundation in normal childhood emotional development, with awareness of the nuances of different ages.

A primary difference is the heavy reliance on verbal communication in counselling with adults. Children are less likely to respond readily to direct verbal questions and more likely to be engaged through the use of other strategies, media and activities in conjunction with talking. While verbal communication is used in counselling with children, play, and non-verbal symbolic means of communication such as art or sandtray, are the primary medium for use with children, particularly younger children. Rather than aiming to get children to talk, the aim of child-focused therapy is to enable them to express themselves and communicate in areas they may find verbally difficult, through use of developmentally appropriate media and methods. Therefore, a shift is required for counsellors who work with adults,

from adapting counselling skills used with adults to using a therapeutic paradigm developed specifically for children, in which play is the medium of communication.

Working with children can involve use of a range of media.

A child counsellor has to understand the meaning of the way a child plays, draws, sings, hides, and builds with bricks. Deciphering their preoccupations, anxieties, defences, hopes and fears is not easy, and counsellors need to become adept in learning this language (Kegerreis, 2006, p.412).

Counsellors working with children have to provide emotional containment for children’s distress by their behaviour as well as by their words. They are working in a complex context that requires them to develop the capacity to contain the child emotionally, to know how to play and think at the same time, and to equip the child with an emotional vocabulary (Kegerreis, 2006).

Although young people might be more verbally adept than children, counselling with them differs significantly from counselling with adults. Geldard and Geldard (2010) argue for a specific approach that recognises that young people do not yet have a full sense of personal autonomy, are in a developmental process of identity formation and individuation and have different goals from adults.



In addition, adults are very rarely 'sent' for counselling. Counselling is a voluntary activity. In contrast, the vast majority of children and young people who attend counselling do so (at least in the first instance) because they have been sent (Prever, 2010). If children have been sent to counselling by a parent, teacher or other adult, the counselor requires skill to find out the child's perception of the situation or difficulties and engage them fully (Kegerreis, 2006).

Goals of counselling

Children, young people and parents are all likely to have differing goals of what they want to achieve from counselling or therapy. Geldard and Geldard (2008) identified four different levels at which goals can be set – fundamental goals, which are globally applicable to all children in therapy; the parents' goals, usually based on parents' agenda and some aspect of the child's current behaviours; goals formulated by the counsellor, as a consequence of hypothesising what underlies some behaviour of concern; and the child's goals, which emerge during the therapy session. They argue that fundamental goals are best achieved by giving precedence to the child's goals while attending to parent and counsellor goals.

Robson (2010) suggests a theoretically neutral definition of the goals of therapy:

the five main goals in present day intervention for children's problems are to reduce overt problems, to promote normal development, to foster autonomy and self reliance, to generalise therapeutic gains and to foster the persistence of these improvements (p.248).

Therapeutic work can also contribute to children's resilience (alongside other characteristics and factors), by providing a support system which aids in coping and provides positive models for identification (Robson, 2010).



Attitudes to counselling children

Counselling occupies something of an ambivalent position in both community and professional contexts. In a community context, there can be stigma associated with seeing a counselor. In a professional context, Schofield (2008) contends that the counselling and psychotherapy field in Australia is at a relatively early stage of development in comparison to other mental health professions in Australia and development of the counselling and psychotherapy profession in other parts of the world. She argues that this is "evidenced through indicators such as the large number of separate professional bodies, the lack of consistency in definition and standards, the lack of a single rigorous regulatory structure, and the lack of awareness by and/or credibility with external bodies, employers, and the public" (p. 4).

By way of comparison, in the UK counselling is increasingly more acceptable and sought after in mainstream contemporary society (Pattison, 2005). However, even in the UK, counselling with children and young people is still done by a high proportion of counsellors who either have no specialist training at all, or have gained it after their primary generic training (Kegerreis, 2006). This contrasts with the psychotherapy domain, in which child and adolescent psychotherapy has been viewed as a separate discipline for many decades and requires separate training.

3.4 Other therapeutic modalities

Child psychotherapy – psychodynamic approach

Psychodynamic theory derives from the early psychoanalytic therapeutic work of Sigmund Freud. There are a diverse range of psychodynamic approaches from “orthodox Freudian to humanistic ego psychology and object relations, from long term psychoanalytic treatment to brief psychodynamic psychotherapy” (Okun & Kantrowitz, 2008, p.120). These latter approaches extend, modify or emerged as a reaction against Freud’s model (Corey, 2009). Key theorists in the field of child psychotherapy are Anna Freud, Melanie Klein and Donald Winnicott.

The primary focus of psychodynamically-oriented child psychotherapy is unconscious processes, and the way that these (and defences against them), along with biological and instinctual drives, shape emotions and behaviour. Defence mechanisms (such as denial, projection, repression, sublimation, regression, displacement, identification) are employed by individuals to help cope with anxiety arising from unconscious processes. These defences, which initially are a form of adaptation for individuals, can then become obstructive, interfering with children’s development and relationships.

Child psychotherapists focus on children’s inner feelings and understandings and how they see and experience their environment. They aim to allow

children to express these by means of play, drawing, words or other behaviour (Passey, 2005). Through observation and dialogue they identify patterns of behaviour and seek to clarify the unconscious motivation for, and meaning of, those patterns. The child’s relationship with the therapist is the primary therapeutic medium, providing a space in which change can occur and allowing for interpretation of unconscious meaning.

Key concepts in this type of therapy, which are useful in other relationship contexts, are transference and countertransference. *Transference* occurs when a person (in child psychotherapy – a child) displaces feelings, attitudes or qualities, that have their origins in previous experiences with significant people, onto others (the therapist), and then begin to relate to the other as if they were that person from the past (Prever, 2010). *Countertransference* occurs when the other person (the therapist) begins to act in ways evoked by the child, the child’s transference or the therapist’s own previous experiences. Developing an understanding of transference and countertransference can help make sense of behaviours and relating which do not seem appropriate, congruent or helpful in certain situations.

Child psychotherapists usually undergo specialised postgraduate training, which includes clinical training, lengthy mother infant observation, and their own intensive personal psychotherapy (Passey, 2005).



Play therapy

In contrast to psychodynamic child psychotherapy, the focus of play therapy is not on interpretation but rather on a belief that children have the capacity to understand and heal themselves given an environment that supports this.

Play therapy can be both directive and non-directive. However, it is generally the non-directive approach that is associated with play therapy. Child-centred play therapy is an adaptation of the humanistic/existentialist approaches to therapy originally developed for working with adults (in much the same way as child psychotherapy is an adaptation of psychoanalytic approaches to working with adults). A key original contributor to this field was Carl Rogers, the creator of client (or person) centred counselling.

Whereas in psychoanalysis the emphasis had been on the therapist's analysis and interpretation of the client's behaviour, Rogers (1955, 1965) believed that clients had the ability to find their own solutions in an environment where there was a warm and responsive counselling relationship (Geldard & Geldard, 2008, p.34).

Non-directive play therapy, developed by Virginia Axline, is closely aligned with person-centred therapy. The role of the non-directive play therapist is to provide the space in which healing through play is possible. Therefore, it is the play itself that is the therapeutic invention. Axline described non-directive play therapy as:

an opportunity that is offered to the child to experience growth under the most favourable conditions. Since play is his natural medium for self-expression, the child is given the opportunity to play out his accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment, confusion (Axline, 1969, p.15).

It is essential that the therapist respects totally the wishes and feelings of the child. It is the child who dictates the process of therapy, and the therapist who enables him or her to do so.

Key characteristics of the child-centred counselling and play therapy relationship are congruence, empathy and unconditional positive regard. Play is the primary medium of communication and speech the secondary medium. The approach is therefore particularly useful for children who have difficulty



expressing themselves verbally. Play therapy and child psychotherapy usually both take place in dedicated therapeutic playrooms, although the principles of both forms of therapy mean that they are portable.

Other creative therapies

There are a range of therapeutic approaches which can be described as creative therapies. These include: art therapy, music therapy, drama therapy, narrative therapy, and sandtray therapy. Play therapy (as outlined above) is also a creative therapy. Visual images, materials and objects are used as the medium for the development of a therapeutic relationship, allowing for additional and alternative means of communication such that children can explore their emotions and feelings in a safe and facilitating environment. Creative therapies offer a non-verbal means of communication for children who may have some difficulty articulating their feelings verbally (Josephs, 2005).

Art therapy, for example, might include working with (amongst other media) painting, drawing, sculpture, model-making or collage. It can be a safe way of expressing thoughts and feelings as the focus is on the activity, rather than the young person's ability to express themselves verbally (Prever, 2010).

Creative therapies, in particular art therapy, thus differ from other psychological therapies in that they represent a three-way process "between the client, the therapist and the image or artifact, offering a *third dimension* to the process" (Josephs,



2005). The art activity provides a medium (other than verbal) for both conscious and unconscious expression.

Of key importance is that therapists have training in the particular creative modality they are using. A South African study looking at school counsellors' use of sandtray therapy highlighted that:

too often counsellors, psychologists and social workers engage in creative expressive arts activities, such as sand tray work, without proper training and a clear understanding and insight regarding the power intrinsic to such activities and the risks it can pose... Like any kind of counselling intervention, the sand tray is only as effective as the counsellor feels competent (Richards, Pillay & Fritz, 2012).

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) restructures negative thoughts into more positive effective ways of thinking. The key principles underlying this approach are: the realisation that thought processes affect our feelings and behaviours; that young people's problems can be exacerbated by maladaptive thinking styles; that these maladaptive thinking styles can be identified; and that young people can be helped to change their thinking style attributions and consequent behaviours (Cooper, 2005). Essentially, the underlying premise is that people can change their emotional state by making changes to their thinking.

CBT combines techniques from behavioural and cognitive therapies, and is based on the premise that cognition is related to mood and behaviour. CBT promotes behavioural and emotional change in

children and young people by "helping them to change their thinking in ways that are interactive and based on problem solving" (Pattison & Harris, 2006, p.100).

Following assessment and formulation, CBT uses strategies and tools such as: redefining the presenting problems, training children and parents to monitor problems, communication skills training, problem solving skills, training parents in supportive play, using reward systems, and cognitive restructuring (Cooper, 2005). It can include work on stress management strategies, relaxation training, practicing coping skills, and other forms of treatment.

CBT can be useful for older school age children and young people who are depressed, anxious or having problems with stress. The cognitive skills that school age children are developing, such as perspective taking, logical thinking, improved understanding of cause and effect, and increasing executive functioning, make it possible to intervene therapeutically in ways that help them make sense of negative affects or stressful experiences (Davies, 2011).

Parent-child therapies

Parent-child therapies are generally aimed at younger children up to, and including, primary school age. They encompass behavioural interventions and psychotherapeutic interventions, and target the interactive relationship between the child and parent, with the aim of strengthening relationships and changing parent-child interaction patterns. There are a range of specific interventions, programs and therapies including:

Child Parent Psychotherapy/Infant Parent Psychotherapy; Interaction Guidance; Watch, Wait and Wonder; Circle of Security; Parent and Infant Relationship Support (PAIRS); Mellow Parenting; and Parent-Child Interaction Therapy (PCIT).

There are a number of behaviour-focused, parenting training programmes available which are effective in reducing 'problem behaviour'. The factors associated with improved outcomes of these include:

in vivo training involving the parents and their own children; a focus on positive interactions between parents and their children; teaching skills related to emotional communication; and training in clear strategies for problem behaviours (Merry, 2009, p.6).

Results of some studies suggest that psychotherapeutic interventions may need to be specifically tailored to the parent's psychological functioning. For example, a number of randomised control trials have produced evidence of the efficacy of child parent psychotherapy in families where there are a number of risk factors including physical abuse and or neglect of children, family violence and parental mental illness (Merry, 2009).

Family therapy

Family therapy "focuses on helping the family function in more positive and constructive ways by exploring patterns of communication and providing support and education" (American Academy of Child and Adolescent Psychiatry, 2011, p.1). It involves working with the family as a system, rather than individual members.

While the individuals in the family are as important in family therapy as in individual therapy, family therapists also deal with the personal relations and interactions of the family members, both inside the family and in the therapeutic system which comprises the family, the therapist or therapists, and their broader community (Australian Association of Family Therapy, 2011).

If the child was the stated reason for referral to family therapy, his or her behaviour is usually seen as a sign of problematic family dynamics. Family therapy might lead to the parents' better understanding of their child and significantly affect their communication with, and emotional attitudes toward him or her (Oren, 2012).

Group Therapy

Group therapy is used in many contexts and, as the name implies, is a therapeutic approach which involves a number of children and one or more therapists. It is

based on an understanding of group dynamics, in the context of the 'here and now' situation, with a focus on the personality and behaviour of each child, the relationship between peers, and the nature of each child's relationship with the therapist (Reid & Kolvin, 1993).

The therapist aims to establish a safe atmosphere, in which all participants in the group feel accepted and respected. Group therapy uses the power of group dynamics and peer interactions to increase understanding of the shared issue and/or improve social skills (American Academy of Child and Adolescent Psychiatry, 2011).



Different therapies in perspective

“No one therapeutic approach is necessarily dominant in terms of effectiveness” (Prever, 2010, p.70). All, however have a common aim: the alleviation of distress and the promotion of emotional health (Carrol, 1998). Much therapeutic work with children is eclectic, drawing on a range of therapeutic modalities. While the techniques available to practitioners range from non-directive to focused methods, the needs and circumstances of the child together with the defined goals assist in the selection of an appropriate intervention.

3.5 Critical issues in referring children and families to specialised services

There are a number of factors which impact on referring children and or families for support and contribute to determining the degree to which it is straightforward and/or successful. These can include: the availability of appropriate individuals or agencies to refer to; the willingness of the child or young person to be referred; the support or reaction of other important people in the child’s life to engaging with the services; and the ability of the support person to make a successful referral.

Range and availability of services

Lack of available services is particularly likely to be an issue in remote, rural and regional areas. While the majority of Australian children aged 10 to 14 years live in major cities, in 2010 33% lived in regional and remote areas (Australian Institute of Health and Welfare, 2012). Roufeil and Battye (2008) cite evidence suggesting that, in Australia,

rural disadvantage is chronic and requires long-term commitment to the delivery of a range of services, including family and relationship programs... and effective support to children, young people and adults so they can develop and sustain safe, supportive and nurturing relationships (p.2).

This is an issue for all children living rurally, but it is particularly important to note that while only three per cent of Australian children lived in remote areas in 2010, 23% of the Indigenous children population live there (Australian Institute of Health and Welfare, 2012).



Referrals of children and families to appropriate agencies and services, when such services are available, can also be negatively affected as a consequence of resource limitations. In an effort to maximise the value and impact of the limited resources available, services establish guidelines for what will be provided, for how long and to whom (Tilbury, 2007). Consequently, children who require services for longer than the guidelines allow, or beyond the scope, simply may not have their needs met. Similarly, there may be gaps in service provision.

What if counselling services are not available?

A not uncommon dilemma to arise is who to refer the child or young person to if there are a lack of suitable counselling professionals or agencies in easily accessible proximity. A relatively recent development that has potential for areas in which counselling services are not available is online internet counselling. The benefits of online counselling for young people include the delivery of services to almost any location and to groups that might not access traditional counselling services; with the possibility of early and preventative intervention (Bambling, King, Reid & Wegner,

2008). However, there are unique challenges in engaging and communicating through text, which are particularly important given the relational basis to counselling and key nature of the therapeutic alliance.

An Australian study of online counselling found that the main benefit for young people was a sense of emotional safety, due to the reduced emotional intensity, with the lack of face-to-face contact being experienced as less intimidating and confronting (Bambling et al., 2008). Challenges include the time involved in typing responses and hence slower discourse, the absence of verbal and non-verbal cues, which may lead to inaccurately assessing the concerns, and difficulty building adequate relationships in a timely manner during sessions (Bambling et al., 2008; Williams et al., 2009).

Evidence suggests that telephone counselling is associated with better counselling outcomes and stronger therapeutic alliance than online counselling (King, Bambling, Reid, & Thomas, 2006). The most likely explanation for this is “the greater communication efficiency of telephone counselling, which enables more counselling work to be undertaken in the time available” (p.175), rather than a stronger alliance. Despite the differences between modes of counselling, communication and service delivery, the findings indicated that:

counselling had a positive effect in both the telephone and online conditions and, overall, young people were significantly and substantially less distressed at the end of the

counselling session than they were at the beginning (King, Bambling, Reid, & Thomas, 2006, p.179).

The Australian study cited here involved young people with an average of 13.1 years in the telephone counselling sample and 15.4 years in the online counselling sample. Telephone and online counselling are unlikely to be suitable for younger children given the emphasis on verbal or written communication. It is also important that guidelines for these counselling methods are transparent and practice monitored.

What if care and protection service are not available or don't accept the referral?

Care and protection services generally function with tight resources and are stretched to their fullest capacity in trying to manage referrals. Consequently, referrals are triaged with the most critical and urgent being acted on soonest. It is not an infrequent occurrence that situations which are of concern are not sufficiently critical to cross the threshold needed to be acted on. These situations are a source of concern for all, including the workers in the child protection agencies and the person wanting to make the referral.

In addition, children and families who have been involved with, or assessed by, a child protection agency are not necessarily monitored intensively and the reality is that many children live in environments that have the potential for violence in one form or another (Kress et al., 2012).



A Canadian study found that the majority of cases that involve child abuse and/or child exposure to domestic violence do not result in the removal of the child from the home, but that removal from a violent home is much more likely when additional reports are factored in (Black et al., 2008). Consequently, it is critically important to continue monitoring the situation and making further notifications if necessary, regardless of the response from the initial referral. It is important to thoroughly document concerns, notifications reported and safety plans developed.

In some locations there may be community based services and agencies who are able to offer support to families where there may be child protection concerns. Cashmore (2009) contends that, while the responsibility for child protection is still assumed by, or assigned to, the statutory department, rather than being taken up more broadly by other services there are many children reported to statutory bodies who do not need a statutory response, but rather their families do need assistance.

If children are left in a potentially unsafe environment or languishing on a waiting list, their safety can be enhanced by developing a safety plan (Kress et al., 2012). Research indicates that children living in potentially violent environments can use emotion-focused or physical-focused coping skills and strategies. These can be beneficial, however they can also lead to mental health problems (for example, passive emotion-focused strategies such as ignoring what is happening, listening to loud music can lead to dissociative states) or may be dangerous (for example, active physical-focused strategies such as fighting with the violent perpetrator, trying to divert their attention or fleeing).

An alternative approach can be working with children to develop a safety plan that enables them to act dynamically on their own safety. Safety plans should be specific and conveyed in a manner that is appropriate to a child's understanding. They should include resources for the child such as local hotlines and telephone numbers of the local police, as well as safe escape routes should they be needed (Kress et al., 2012).



Supporting the referral

Relationships are central to facilitating referrals, including the referring person's relationships with the child or young person, the parents and the agency. Depending on the context, collaboration with other professionals can be an important aspect of supporting referrals and ongoing agency involvement.

Effective collaboration between practitioners has been found to reduce duplication and overlap, improve role clarity, improve systems for referral, information sharing and joint decision making, and result in clearer interagency child protection plans and protocols. Consequently, it leads to individual practitioners, professionals and agencies being inclusive of other resources and supports that may be available (Gilligan, 2005), and better placed to support children and families, with better outcomes likely (Tilbury, Osmond, Wilson & Clark, 2007).

Multi-professional collaboration entails valuing others' perspectives, learning from each others' practice and knowledge, respecting professional differences and engaging in collaborative planning (Tilbury et al., 2007). Collaborating in such a way, professionals model appropriate communication to children, families and others (Atwool, 2000, p. 27).

Depending on the age of the child and the issues of concern, it is also important to engage parents when making referrals to support agencies. Counselling and therapy, for example, can only be a supplement to the 24 hour a day care that children usually receive from parents, so it is important that parents are supported and given practical strategies too (Atwool, 2000). Particularly in child protection, if the agency or service is perceived as ‘the enemy’ children and parents are unlikely to provide information, cooperate with the design and implementation of safety plans, and may lead to children continuing to be at risk (Tilbury et al., 2007).

Stigma associated with the referral

A hindrance to referral can be the stigma associated with either the issue or the organisation being referred to, for example, in the case of mental health referral. “Stigma involves the deep discrediting of an individual as a function of his or her membership in a devalued group with low social power” (Heflinger & Hinshaw, 2010, p.61). Stigma, in relation to mental health, can have an influence:

- at a systemic level - on the policies that govern the nature of, access to and funding for treatment and support, eligibility for social assistance or the right to refuse treatment;
- at a community level - on how organisations including social service agencies, employers, health care providers, or schools respond to

individuals with a mental illness and to their families; and

- at the individual level - prohibiting people from seeking the treatment they need, creating profound changes in identity and changing the way in which they are perceived by others (Scheffer, 2003).

The consequences of stigmatisation include a lack of recognition that certain behavioural patterns may signify a mental health concern and a sense of shame in children and families. Both of these may contribute to children and families not being referred or seeking from the involvement of mental health professionals

Heflinger and Hinshaw (2010) contend that stigma regarding mental health comes not only from the general population but also from within the mental health profession. They argue that professional and institutional stigma may be expressed toward children with mental health issues and their families in many ways, on conscious and unconscious levels, wither indirectly or directly. For example, children may be referred to by their diagnosis, rather than labelling the condition (eg “the ADD kid” or “the bipolar girl” as opposed to the child with ADD or bipolar disorder). Professionals may focus exclusively on symptomology and dysfunction instead of taking a whole child approach or identifying individual and family strengths.





Conclusion

Supporting children through difficult times involves the “three R’s” discussed in this Background Briefing: recognising, responding and referring. It is critically important that frontline professionals are able to recognise when some sort of support would be helpful for the child, respond in a way that the child feels respectfully heard and supported, and know when it would be appropriate to refer the child to other professionals or agencies, and how to go about doing this.

Whatever the professional background of the support person is they have a valuable role to play, as part of a community of professionals, organisations and services, who together are all there to seek the best possible outcomes for children and young people. This supportive community is part of the larger fabric of the child’s life. It is important to be aware that,

what we do matters, but we should not succumb to the delusion that a professional at one point in time, or even a set of professionals... are necessarily going to be the most influential forces in a child’s development or recovery. There are many, many forces at work in a child’s life (Gilligan, 2002, p.30).

It is equally important to remember that we are such a force and that what we do, in supporting children and young people through difficult times, might indeed make a difference, temporarily or longer-lasting, for that child or young person.

References

- American Academy of Child and Adolescent Psychiatry (2011). *Psychotherapies for children and adolescents. Facts for families*, No. 86. Available online at: http://www.aacap.org/cs/root/facts_for_families/psychotherapies_for_children_and_adolescents
- Australian Institute of Family Studies (2012a). *Helplines and telephone counseling services for children, young people and parents*. Available online at: www.aifs.gov.au/cfca/pubs/factsheets/a143428/index.html
- Australian Institute of Family Studies (2012b). *Mandatory reporting of child abuse and neglect*. Available online at: www.aifs.gov.au/cfca/pubs/factsheets/a141787/index.html
- Australian Institute of Family Studies (2012c). *Reporting abuse and neglect: State and Territory departments responsible for protecting children*. Available online at: www.aifs.gov.au/cfca/pubs/factsheets/a142843/index.html
- Australian Institute of Health and Welfare (2012). *A picture of Australia's children 2012*. Cat. no. PHE 167. Canberra: AIHW.
- Australian Institute of Health and Welfare (2013). *Child protection Australia 2011-12*. Child welfare series no. 55. Cat. No. CWS 43. Canberra: AIHW.
- Alisic, E., Boeije, H., Jongmans, M., & Kleber, R. (2012). Supporting children after single-incident trauma: Parents' views. *Clinical Pediatrics*, 51(3), 274-282.
- Atwool, N. (2000). Trauma and children's rights. In A. Smith, M. Gollop, K. Marshall & K. Nairn (Eds.), *Advocating for children: International perspectives on children's rights*, (pp. 19-31). Dunedin: University of Otago Press.
- Australian Association of Family Therapy (2011). Family therapy. Available online at: <http://www.aaft.asn.au/family-therapy>
- Axline, V. (1969). *Play therapy*. New York: Ballantine Books.
- Baggerly, J., & Exum, H. (2008). Counseling children after natural disasters: Guidance for family therapists. *The American Journal of Family Therapy*, 36, 79-93.
- Bambling, M., King, R., Reid, W., & Wegner, K. (2008). Online counselling: The experience of counsellors providing synchronous single-session counselling to young people. *Counselling and Psychotherapy Research*, 8(2), 110-116.
- Black, T., Trocmk, N., Fallon, B., & MacLaurin, B. (2008). The Canadian child welfare system response to exposure to domestic violence investigations. *Child Abuse & Neglect*, 32, 393-404.
- Bronfenbrenner, U., & Morris, P. (2006). The bioecological model of human development. In R. Lerner (Ed.), *Handbook of child psychology* (pp. 793-828). New Jersey: John Wiley.
- Campbell, A., & Simmonds, J. (2011). Therapist perspectives on the therapeutic alliance with children and adolescents. *Counselling Psychology Quarterly*, 24(3), 195-209.
- Carroll, J. (1998). *Introduction to therapeutic play*. London: Blackwell Science.
- Cashmore, J. (2009). Relational aspects in the regulation of systems for protecting children. *Communities, Children and Families Australia*, 4(1), 31-35.
- Cooper, M. (2005). Cognitive behavioural therapy. In M. Cooper, C. Hooper & M. Thompson (Eds.), *Child and adolescent mental health: Theory and practice* (pp. 216-221). London: Hodder Arnold.
- Corey, G. (2009). *Theory and practice of counselling and psychotherapy*. California: Brooks/Cole.
- Daniel, B., Wassell, S., Ennis, J., Gilligan, R., & Ennis, E. (1997). Critical understandings of child development: The development of a module for a post-qualifying certificate course in child protection studies. *Child and Family Social Work*, 2, 209-219.
- Davies, D. (2011). *Child development: A practitioner's guide*. New York: Guilford Press.
- Diggins, M. (2011). *Think child, think parent, think family: A guide to parental mental health and child welfare*. London: Social Care Institute for Excellence
- Downey, L. (2007). *Calmer classrooms: A guide to working with traumatised children*. Melbourne: State of Victoria, Child Safety Commissioner.
- Downey, L. (2009). *From isolation to connection: A guide to understanding and working with traumatised children and young people*. Melbourne: State of Victoria, Child Safety Commissioner.

- Faber, A., & Mazlish, E. (2005). *How to talk so teens will listen and listen so teens will talk*. New York: Harper Collins.
- Geldard, K., & Geldard, D. (2008). *Counselling children: A practical introduction*. London: Sage.
- Geldard, K., & Geldard, D. (2010). *Counselling adolescents: The proactive approach for young people*. London: Sage.
- Gilligan, R. (1998). The importance of schools and teachers in child welfare. *Child and Family Social Work*, 3, 13-25.
- Gilligan, R. (2002). Promoting resilience in children and young people. *Developing Practice*, Summer, 29-36.
- Gilligan, R. (2004). Promoting resilience in child and family social work: Issues for social work practice, education and policy. *Social Work Education*, 23(1), 93-104.
- Gilligan, R. (2005). Promoting strengths and resilience in vulnerable children and families. *Children's Issues*, 9(1), 7-11.
- Gilligan, R. (2009). *Promoting resilience: Supporting children and young people who are in care, adopted or in need*. London: British Association for Adoption and Fostering.
- Graham, A. (2011). *Strengthening young people's social and emotional wellbeing*. Centre for Children and Young People Background Briefing Series, no.7. Lismore: Centre for Children and Young People, Southern Cross University.
- Graham, A. & Fitzgerald, R. (2011). Supporting children's social and emotional well-being: Does 'having a say' matter? *Children & Society*, 25, 447-457.
- Graham, A., Fitzgerald, R., Powell, M., Simmons, C. & White, N. (2013, in progress). *Improving approaches to wellbeing in schools: What role does recognition play? Phase 2 ARC project report*. Lismore: Southern Cross University.
- Gross, D., & Capuzzi, D. (2008). Defining youth at risk. In D. Capuzzi and D. Gross (Eds.), *Youth at risk: A prevention resource for counsellors, teachers and parents* (pp. 3-22). Alexandria VA; American Counselling Association.
- Hamilton, M., & Redmond, G. (2010). *Conceptualisation of social and emotional wellbeing for children and young people, and policy implications*. ARACY & AIHW.
- Heflinger, C., & Hinshaw, S. (2010). Stigma in child and adolescent mental health services research: Understanding professional and institutional stigmatization of youth with mental health problems and their families. *Administration and Policy in Mental Health*, 37, 61-70.
- Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse and Neglect*, 32, 797-810.
- Hunter, C. (2011). *Responding to children and young people's disclosures of abuse*. National Child Protection Clearinghouse (NCPC) Practice Brief. Melbourne: Commonwealth of Australia.
- Hunter, C. (2012). *Is resilience still a useful concept when working with children and young people?* CFCA Paper No. 2. Child Family Community Australia Information Exchange. Melbourne: Commonwealth of Australia.
- Jones, E., Gutman, L., & Platt, L. (2013). *Family stressors and children's outcomes*. London: Childhood Wellbeing Research Centre.
- Josephs, M. (2005). Art, drama and play therapies. In M. Cooper, C. Hooper & M. Thompson (Eds.), *Child and adolescent mental health: Theory and practice* (pp. 200-205). London: Hodder Arnold.
- Kegerreis, S. (2006). *Working with children and adolescents: Is specialist training necessary?* *Psychodynamic Practice*, 12(4), 403-418.
- King, R., Bambling, M., Reid, W., & Thomas, I. (2006). Telephone and online counselling for young people: A naturalistic comparison of session outcome, session impact and therapeutic alliance. *Counselling and Psychotherapy Research*, 6(3), 175-191.
- Korzybski, A. (1933). *Alfred Korzybski*. Retrieved October 21, 2005 from http://en.wikipedia.org/wiki/Alfred_Korzybski
- Kress, V., Adamson, N., Paylo, M., DeMarco, C., & Bradley, N. (2012). The use of safety plans with children and adolescents living in violent families. *The Family Journal*, 20, 249-255.
- Lazarus, P., Jimerson, S., & Brock, S. (2003). *Helping children after a natural disaster: Information for parents and teachers*. Bethesda: National Association of School Psychologists. Available online at www.nasponline.org
- Leeson, C. (2010). The emotional labour of caring about looked-after children. *Child and Family Social Work*, 15, 483-491.
- Linke, P., & Radich, J. (2010). *Children's resilience: Working with the Early Years Learning Framework*. Canberra: Early Childhood Australia.

- Lewis, R. (2008). Resilience: Individual, family, school and community perspective. In D. Capuzzi & D. Gross (Eds.), *Youth at risk: A prevention resource for counsellors, teachers and parents* (pp. 39-68). Alexandria VA; American Counselling Association.
- Lundy, L., & McEvoy, L. (2012). Childhood, the United Nations Convention on the Rights of the Child and research: What constitutes a rights based approach? In M. Freeman (Ed.), *Law and Childhood* (pp.75-91). Oxford: Oxford University Press.
- McDermott, B. (2004). Child and youth emotional trauma: An explanatory model of adverse outcomes. *Psychiatry, Psychology and Law*, 11(2), 269-279.
- McDermott, B., Lee, E., & Judd, M. (2005). Posttraumatic stress disorder and general psychopathology in children and adolescents following a wildfire disaster. *Canadian Journal of Psychiatry*, 50(3), 137-143.
- McLeod, J. (2008). Outside the therapy room. *Therapy Today*, 19(4), 14-18.
- Merry, S. (2009). *Interventions for infants and pre-schoolers with mental health problems: A summary of reviews*. Auckland: The Werry Centre for Child and Adolescent Mental Health Workforce Development.
- Mission Australia (2011). *National survey of young Australians 2011*. Sydney: Mission Australia.
- Mission Australia (2012). *Youth survey 2012*. Sydney: Mission Australia.
- Murphy, C., Paton, N., Gulliver, P., & Fanslow, J. (2013). *Policy and practice implications: Child maltreatment, intimate partner violence and parenting*. Auckland: New Zealand Family Violence Clearinghouse, University of Auckland.
- Okun, B., & Kantrowitz, R. (2008). *Effective helping: Interviewing and counselling techniques*. California: Thompson Brooks/Cole.
- Oz, S. (2010). Treatment of individuals and families affected by child sexual abuse: Defining professional expertise. *Journal of Child Sexual Abuse*, 19, 1-19.
- Pattison, S. (2005). Making a difference for young people with learning disabilities: A model for inclusive counselling practice. *Counselling and Psychotherapy Research*, 5(2), 120-130.
- Pattison, S., & Harris, B. (2006). Adding value to education through improved mental health: A review of the research evidence on the effectiveness of counselling for children and young people. *The Australian Educational Researcher*, 33(2), 97-121.
- Passey, M. (2005). Child psychotherapy. In M. Cooper, C. Hooper & M. Thompson (Eds.), *Child and adolescent mental health: Theory and practice* (pp. 196-199). London: Hodder Arnold.
- Perry, B. (1997). Incubated in terror: Neurodevelopmental factors in the 'Cycle of Violence'. In J. Olofsky, (Ed.), *Children in a violent society* (pp. 124-49). New York: Guilford.
- Perry, B. (2002). *Helping traumatised children: A brief overview for caregivers*. Available online at www.childtrauma.org
- Pienaar, F. (2010). *New Zealand children's experiences of stress and coping*. Unpublished PhD thesis submitted to the University of Auckland, Auckland.
- Prever, M. (2010). *Counselling and supporting children and young people: A person-centred approach*. London: Sage.
- Rao, P., Ali, A., & Vostanis, P. (2010). Looked after and adopted children. How should specialist CAMHS be involved? *Adoption & Fostering*, 34(2), 58-72.
- Reid, S., & Kolvin, I. (1993). Group psychotherapy for children and adolescents. *Archives of Disease in Childhood*, 69, 244-250.
- Rheineck, J., & Miars, R. (2008). Stress and trauma: Coping in today's society. In D. Capuzzi & D. Gross (Eds.), *Youth at risk: A prevention resource for counsellors, teachers and parents* (pp. 155-176). Alexandria VA; American Counselling Association.
- Richards, S., Pillay, J., & Fritz, E. (2012). The use of sand tray techniques by school counsellors to assist children with emotional and behavioural problems. *The Arts in Psychotherapy*, 39, 367-373.
- Robson, M. (2010). Therapeutic work with children: A contextual overview. *British Journal of Guidance & Counselling*, 38(3), 247-261.
- Rose, W., & Aldgate, J. (2000). Knowledge underpinning the Assessment Framework. In Department of Health (Ed.). *Assessing children in need and their families: Practice Guidance*. London: The Stationary Office.
- Roufeil, L., & Battye, K. (2008). *Effective regional, rural and remote family and relationships service delivery*. (AFRC Briefing, Number 10). Available online at: www.aifs.gov.au/afrc/pubs/briefing/briefing10.html
- Scheffer, R. (2003). *Addressing stigma: Increasing public understanding of mental illness*. US: Centre for Addiction and Mental Health.

- Schofield, M. (2008). Australian counsellors and psychotherapists: A profile of the profession. *Counselling and Psychotherapy Research, 8*(1), 4-11.
- Sharry, J. (2004). *Counselling children, adolescents and families*. London: Sage.
- Social Care Group (2000). *Assessing children in need and their families: Practice guidance*. London: Department of Health.
- Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148*, 10-20.
- The Werry Centre (2010). *Evidence-based age-appropriate interventions: A guide for child and adolescent mental health services (CAMHS)*. Auckland: The Werry Centre for Child and Adolescent Mental Health Workforce Development.
- Thompson, M. (2005). Introduction: Towards a comprehensive child and adolescent mental health service (CAMHS). In M. Cooper, C. Hooper & M. Thompson (Eds.), *Child and adolescent mental health: Theory and practice* (pp. xi-xiv). London: Hodder Arnold.
- Tilbury, C., Osmond, J., Wilson, S., & Clark, J. (2007). *Good practice in child protection*. Frenchs Forest, NSW: Pearson Education.
- Trussell, R. (2008). Promoting school-wide mental health. *International Journal of Special Education, 23* (3), 149-155.
- Urbis (2011). *The psychological and emotional wellbeing needs of children and young people: Models of effective practice in educational settings*. Australia: Urbis.
- Walsh, K., Bridgstock, R., Farrell, A., Rassafiani, M., & Schweitzer, R. (2008). Case, teacher and school characteristics influencing teachers' detection and reporting of child physical abuse and neglect: Results from an Australian survey. *Child Abuse and Neglect, 32*, 983-993.
- Williams, R., Bambling, M., King, R. & Abbott, Q. (2009). In-session processes in online counselling with young people: An exploratory approach. *Counselling and Psychotherapy Research, 9*(2), 93-100.
- Wilson, K. & Ryan, V. (2005). *Play therapy: A non-directive approach for children and adolescents*. Oxford: Elsevier.
- Wolf, K., & Krebbs, F. (2008). Maintaining professional boundaries in interpersonal work. Available online at: www.first5scc.org/

About the Centre for Children and Young People

The Centre for Children and Young People (CCYP) was established at Southern Cross University in 2004. The CCYP works collaboratively with organisations, particularly in regional and rural areas, to enhance policy and practice related to the well-being of children and young people.

The Centre has three priority areas: Research, Education and Advocacy.

**For more information about the CCYP, visit
ccyp.scu.edu.au**



About the Course

The Graduate Certificate, Graduate Diploma and Master of Childhood and Youth Studies are awards which have been developed collaboratively by the Centre for Children and Young People and the School of Education at Southern Cross University, Australia. The awards meet a recognised need, expressed by a range of professionals, for contemporary knowledge and skills to assist them to work more effectively with children, young people and their families.

The course seeks to be an innovative, professionally relevant, practical and interdisciplinary qualification for people working, or intending to work, with children, young people and their families. Applicants can enrol in any one of the awards or complete individual units as professional development.

Units are delivered externally so that students can successfully study at a distance. Each unit has authentic and professionally relevant assessment and the five core units involve optional but highly recommended summer/winter intensive workshops of 2 days duration. Students who are unable to attend are able to engage with workshop content and processes live online or via recorded formats.

The course incorporates innovative and appropriate use of technology to support students' learning, opportunities for regular engagement with tutors and fellow students and (where appropriate) multimedia elements.

The course is underpinned by a deep respect and regard for children and young people and for their views and perspectives. It also incorporates an understanding that children and young people can benefit immensely from positive relationships with adults – parents, teachers and the myriad professionals with whom they may engage over the course of their childhood. The course embraces multidisciplinary perspectives in the belief this can enhance service provision and lead to improved outcomes for children and young people.

**For more information about these awards, visit
www.scu.edu.au/chilhoodstudies**

Centre for Children and Young People



research, education & advocacy

Centre for Children and Young People
Southern Cross University
PO Box 157
Lismore NSW 2480

Phone 02 6620 3605

Fax 02 6620 3243

Email: ccyp@scu.edu.au

www.ccyp.scu.edu.au

