

3 “Who Will Comfort Toffle?” – Creating Audiences for Children’s Preferred Futures

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Now once upon a time, although not very long ago,
And Hidden in the forest where the tall dark pine trees grow,
There lived a boy called Toffle in a house that stood alone.
He always felt so lonely, and one night was heard to moan;
“I feel so frightened of the dark, especially tonight.....”

Who Will Comfort Toffle – Tove Jansson (1960)

In this tale from the Moomin Valley Toffle finds himself driven from his home by the frightening noises of the forest. All alone, and too shy, at first to approach the many Moomin characters he passes along the way, he gains confidence by helping a scared and lonely Miffle who needs help more than he does. Toffle’s quest to save Miffle from the dreadful Groke inspires him to move beyond his own fears and anxieties, and at the same time create an audience to listen to his preferred future.

What would happen if Toffle were alive today, living within a community with all his worries and anxieties, his fear of the dark and the noises of the forest? Maybe Toffle refuses to go to school or becomes aggressive when asked about his fears and worries? Maybe his parents are concerned about his social isolation or potential depression? In all probability Toffle would be referred to a child psychiatrist or a therapist. He would be evaluated, assessed, diagnosed with any number of conditions and disorders, or perhaps his parents would be mandated to attend parenting classes?

The Culture of Child and Adolescent Mental Health

The world of child and adolescent mental health has become dominated by a psychiatric model, which places emphasises on diagnosis, the extensive use of medication and has resulted in increasing numbers of children being diagnosed with ‘psychiatric’ illnesses (Timimi and Maitra, 2005). So pervasive and extensive is this model that many health, social and educational professionals

have resigned themselves to a culture that 'recruits' therapists into resignation (Nylund, 2002).

A context is created in which the child psychiatrist, the family therapist, the social worker etc. assume an 'expert position' which has pitfalls for both the child and the helping professional. Professionals who embrace their own expertise over that of the child or parent, become convinced that their assessments are real, true and objective (Nylund and Corsiglia, 1996). Hubble and O'Hanlon (1992) refer to this occurrence as "delusions of certainty" (p.26). According to Selekman (1997; 2005) one of the consequences of this is that the knowledge, the expertise and the voice of the child and adolescent are diminished and a language of deficiency is created which creates a kind of 'therapeutic black hole' (Selekman, 2005). In this context it is difficult for the clinicians or the child and family to construct any other kind of language or reality.

Child and adolescent mental health services place emphasis on descriptions of what is wrong, broken, absent, or insufficient with the child and his/her family. An example of the dominance of this language can be seen in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). Apart from listing an ever increasing number of childhood disorders, it does not provide clinicians with any practical treatment guidelines for these disorders, and makes no mention of the child's strengths, resources and competencies.

Maddux (2002) maintains that there are four 'faulty' assumptions about the DSM: (1) the categories of disorders are facts about the world; (2) we have the ability to distinguish between normal and abnormal behaviours; (3) the categories of disorders facilitate clinical judgment; and (4) the categories of disorders help facilitate the planning process. According to Selekman (2005) the DSM does not take into consideration the impossibility for the helping professions to be objective and bias-free when it comes to the assessment and the diagnosis of children's behaviour. As Maddux (2002) points out, there are many truths and none of these is more correct than another and ultimately we lack the scientific methodology for accurately determining if a child is normal or abnormal.

Although child and adolescent mental health professionals listen to children, consult them and invite them to meetings, in the final analysis, as adults they consider that they know what is in the child's best interests (Milner, 2001). This retention of expertise by adults in traditional child and adolescents mental health services would not be a problem if it could be proven that children themselves benefited.

As White (1999) commented, the social construction of children as vulnerable dependants incapable of finding solutions to their own problems and difficulties has not served children particularly well. According to Mullender (1999) the use of the term 'in the child's best interests' describes

how a well-meaning adult views a child’s relationship with that adult and, when that relationship ‘goes wrong’, the child is often ‘totalised’ within a pathological and diagnostic discourse. The child or the parent is then encouraged to accept and admit to this diagnosis or label, and if they do not, then they are seen as being in denial, uncooperative or resistant to change.

Narrative Therapy with Children

Narrative therapy was developed by Michael White and David Epston as a form of family therapy (White and Epston, 1989, 1990), and is part of a wider movement within philosophy, the humanities and the social sciences (Besley, 2002). This movement emphasizes the significance of shared language in the social construction of reality (White and Epston, 1990; Corey, 2001). Social construction holds that individual behaviour, relationships, aspirations and expectations derive for the social construction of self, which is formed through a shared language (DeSocio, 2005). From this position, a child’s view of reality, and ultimately themselves, is always a selective representation and this representation is often dictated to the child by the mental health professionals or the other adults in the child’s life.

The language of child psychiatric theory and practice often blurs, alters or distorts the child’s stories of success and resilience preferring instead to focus on deficits, diagnosis and the part the child played in helping to create and maintain the problem. According to White and Epston (1990) these self-narratives are often held as true representations of self and lived with real effects and consequences.

In therapeutic conversations with children narrative therapy uses a variety of techniques to deconstruct, expose and subvert the dominant patterns of relating; patterns that the child often finds problematic. By challenging the dominant psychiatric constructions that are often given to children, it opens up the possibility that space can be provided for change to occur.

The key to this approach is the assumption by the narrative therapist, that all children have both personal and local knowledge (Besley, 2002), as well as the skills, competencies and abilities that they can use to solve their problems and difficulties. Techniques such as engaging in externalizing conversations, and helping the child to give a name to the problem, aim to stop children and their parents becoming disabled by the problem.

In this context conversations with children are focused on creating dialogue, with the aim of helping them learn about the meaning they attached to events and experiences.

Unlike other approaches these conversations examine the wider socio, political and cultural assumptions that may be helping to create and maintain the problem. By trying to help the child work out how these influence the

dominance of the problem, they can be helped to look out for ‘sparkling moments’, or those unique times when the child has gained some control over the problem, or has successfully challenged and defeated the problem, which can then be used to help the child find different ways in which they would prefer to describe themselves.

The concept of language underlying narrative therapy is indebted to the work of Wittgenstein (1953), in which language is not just found or discovered, it is part of the culture and is based on societal criteria or rules. The way in which narrative therapy helps children find alternative stories, positions the approach in direct opposition to the culturally biased and biologically based psychological theories, which assume that children’s behaviour is determined by some underlying structure or dysfunction.

Creating Audiences for Stories that Children want to Tell

Robert, aged 9, was referred to the Child and Adolescent Mental Health Service (CAMHS) by his General Practitioner (GP), after his mother had been to see her because of concerns about persistent temper tantrums, over activity, difficulty concentrating and refusing to come in the house at night time. The GP, and indeed most of the school professionals, had concluded that Robert had Attention Deficit Hyperactivity Disorder (ADHD). After seeing a Child Psychiatrist, and later a Family Therapist, the conclusion was that he did indeed have ADHD. He was subsequently prescribed medication in order to control various aspects of his behaviour.

At the first meeting with his parents they described Robert’s ‘problems’ as “Robert’s attention-seeking behaviour”, and expressed the view that Robert had ADHD. They produced several reports from school, which portrayed Robert in a very negative way. I then asked to talk with Robert, with his parents present, and invited him to engage in an externalizing conversation (White and Epston, 1990). I suggested that ADHD was a Doctor’s name for some of the concerns that his parents and the school staff had, and I asked him to name the problems. He became more animated and named the difficulties *Billy Whizz*, a reference to a comic character in *The Beano Comic*.

I then spent some time talking with Robert about the effects that *Billy Whizz* was having on his life. The questions included:

- Does Billy Whizz like trouble?
- What does Billy Whizz get you to do?
- What does Billy Whizz do to your parents and teachers?

According to Zimmerman and Dickerson (1996) externalizing questions, in which the child is encouraged to see the problem as an active agent in the

child’s life, can help the child see that the problem is the problem and not themselves. The use of these questions also helped his parents see that Robert was more than a list of presenting problems, and in talking about ways in which Robert had challenged, and on occasions defeated *Billy Whizz*, they began to see that Robert was a child that showed considerable strengths, resources and competencies, in stopping *Billy Whizz* from taking over his entire life. In the course of asking these questions it soon became clear that Robert felt that *Billy Whizz* was not a friend of his, but an enemy that needed to be defeated.

The Battle and the Defeat of ‘Billy Whizz’

During the rest of the initial session, and the subsequent meetings I had with Robert, I spent time talking with him about the exceptions to the *Billy Whizz* story. This involved locating times when Robert and his parents had resisted the problem-saturated story, or had taken effective action against *Billy Whizz* (de Shazer, 1995). The questions included:

- Has there been times when *Billy Whizz* could have taken control in class, but somehow you did not allow him to do this?
- Are there times when *Billy Whizz* tells you what to do but you ignore him?
- Did *Billy Whizz* want you to come and see me? Why do you think *Billy Whizz* is not so keen on you coming to see me?

The main purpose of these types of questions is to make the child an expert, not only in their own problems, but in their solutions. Traditional therapies often claim that change is slow and arduous (Nylund, 2002), and often rely on the expertise of the professional involved. By placing the child at the centre of the change process the pace of change is controlled by the child and not the professional. The result of this is that change occurs quicker than either the parents or professional expect.

Robert was able to tell me about an occasion when *Billy Whizz* had wanted him to ‘mess about’ in class when he was painting a picture, and an occasion when *Billy Whizz* wanted him to throw a pencil at another member of the class. On both occasions Robert had resisted the pressure to do this, and had taken action to challenge and defeat *Billy Whizz*.

From these conversations it soon became clear that Robert, and his parents, had a wide range of special abilities that they used in their attempts to defeat *Billy Whizz*. The numerous exceptions to the problem dominated story allowed the construction of an alternative story, a story that was able to stand up to the power of *Billy Whizz*. Robert and his family supported by child psychiatric and

school professionals had begun to believe that the *Billy Whizz* story spoke the truth about Robert.

The skill of using narrative therapy questions with children, lies in carefully assembling, a sub-plot to the existing problem-dominated story. This story needs to be invigorating, colourful and compelling (Winslade and Monk, 1999). This sub-plot emerges as we discuss with children the effects of the problem on the child's life, and then eliciting exceptions. These moments need to be listened for and amplified within the home, school and the wider community.

Telling and Celebrating the Preferred Story

Having elicited exceptions to the story *Billy Whizz* wanted for Robert, new stories emerged that needed an audience. These new stories only take root if there is an appreciative audience. Robert was used to an audience that was focused on the negative aspects of his behaviour. According to Freedman and Combs (1996, p.237):

Although in the dominant culture therapy tends to be a secret enterprise, in the narrative subculture the people who consult with us are usually enthusiastic about the idea of letting other people in on the process. We think that externalizing and antipathologizing practices offer people a different kind of experience in therapy. When therapy becomes a context in which people constitute preferred selves, they have nothing to hide, and much to show.

Throughout the session I had with Robert the professionals involved were invited to attend the sessions, and see the development of the alternative story. Once the new story had emerged it was time to invite an audience and I asked Robert a number of questions:

- Now that you have taken control over Billy Whizz, who else would celebrate it with you?
- Who needs to be told about the changes you have made in defeating Billy Whizz?
- How would you let you mum and dad and your teachers know that you have improved your behaviour?

Anderson and Goolishian (1988) suggest that problems are maintained through language and social interaction. Many children experience systems that become involved in describing and directing their lives and the lives of their families. It is essential that representatives of these problem-dominated systems are invited to hear the new stories that children tell.

I helped Robert design some invitations to members of his family, his teachers and some of the other professionals involved in his life. We then arranged a celebration, in which various professionals and members of his family talked about the alternative story that Robert had created. These celebrations are very important, and Robert hosted a ‘*Defeating Billy Whizz Party*’. At the final interview with Robert and *Billy Whizz*, it was clear that he had successfully defeated *Billy Whizz* and created an audience for his preferred story.

Who Will Comfort Toffle?

At the end of the story Toffle faced his worst fears, the dreaded Groke on a cold desolate landscape. He knew it would not be easy, but inspired by the challenge of creating an alternative story, he ran at the Groke and bit her in the heel. And taken by surprise the Groke screamed and ran away.....

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