ESSENTIAL RESEARCH FINDINGS

in CHILD and ADOLESCENT COUNSELLING and PSYCHOTHERAPY

EDITED BY

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INTRODUCTION: WHAT CAN CHILD THERAPISTS LEARN FROM RESEARCH?

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This chapter discusses

- The rationale for integrating research evidence into therapeutic work with children and young people
- The emergence of the concept of 'evidence-based practice'
- The limits of research evidence
- The value of research evidence
- The aims of this book
- The format of this book and its chapters
- Our reflections, as co-editors, on the stances we bring to this book

Talia sits in her chair staring blankly at her therapist. It's the start of the second session. Talia is 14, and has been referred to therapy because she's missing school, unable to concentrate in class, and getting into fights with her parents. Talia's therapist can feel her anger and resentment bubbling underneath the surface. In the first session of therapy, Talia talked about how she hates her mum now, how things at home are 'rubbish' and that she doesn't get to do what she wants because she's always looking after her little brother. It's been like that, she says, since her nan died. The first session seemed to go ok: Talia told her therapist a bit about what's been happening and set some goals for the therapy work, including that she wanted to be able to get on better with her mum. But now, sitting opposite Talia who stares blankly into space, the therapist is wondering what to do next, and how to help Talia find some way of expressing herself and getting the support and help she needs.

What can reading a book about research findings offer to the woman sitting with Talia, when trying to help her work effectively as a child therapist? Traditionally, most counsellors and psychotherapists would probably have said, 'Not much'. In an interesting study of the 'Utilization of psychotherapy research by practicing psychotherapists', Morrow-Bradley and Elliott (1986) found that the typical psychotherapist does not find research studies useful to practice. The psychotherapists said that they didn't feel that the variables selected in most research studies reflected actual clinical practice; data analyses overemphasized group statistics and statistical significance against the particularity of the clinical encounter; research findings were not translated into a clinically useful format; and they often lacked the suitable training, or were simply too busy, to read research papers. Consistent with this, when counsellors and psychotherapists are asked in what ways they learn most about their work, studies have consistently found that 'research' is bottom of the list – below clinical experience, supervision, personal therapy, case presentations and discussion with colleagues.

So what is the reason for this research–practice gap? In another interesting study, Darlington and Scott (2002) found that psychotherapists associated the word 'research' with such terms as 'hard', 'cold', 'scientific', 'factual', 'time-consuming' and 'tedious'. By contrast, the same participants associated the word 'practice' with such terms as 'subjective', 'people', 'messy', 'soft', 'warm', 'flexible' – clearly, a more positive set of associations.

Despite these findings, this book aims to make the case that therapeutic work with children and young people can benefit from an engagement with the research evidence. As we will elaborate on later in this introduction, this does not mean that research evidence should be treated like some form of deity that we all need to worship (Cooper, 2008). Other sources of inspiration – such as clinical experience, supervision, personal therapy, case presentations, discussion with colleagues – can all have enormous value. But research evidence is one source of knowledge frequently overlooked by therapists, and we think it is an essential one. Still, today, we train practitioners in all sorts of different practices with children and young people without knowing enough about what the research findings can tell us. Too much theory and not enough evidence: the aim of this book is to try and redress the balance. So that, when we are sitting there with a young person like Talia, we can draw from our training, and we can draw from our theoretical knowledge, and our experience as therapists, but we can also draw from the research findings – a treasure trove of knowledge that is just waiting to be unlocked.

The birth of evidence-based practice

Since Morrow-Bradley and Elliott (1986) surveyed therapists in 1985, there has been an increasing focus on engaging with, and drawing on, empirical research – often promoted under the umbrella term 'evidence-based practice' (EBP). This can be defined as 'the conscientious, explicit and judicious use of current best evidence in decision making about the care of individual patients' (Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996: 71). In practice, this means integrating individual clinical expertise with the best available external evidence from systematic research.

If there is one person who is probably responsible for the concept of EBP, it is a Professor of Tuberculosis and Chest Diseases called Archie Cochrane. In 1972 Cochrane wrote a book called *Effectiveness and efficiency: Random reflections on health services*. In it, he made a powerful attack on the medical establishment of his day, in which he argued that 'chaotic, individualistic, often ineffective and some-times harmful' patterns of care were the norm, largely due to the fact that medi-cine itself had not organized its knowledge 'in any systematic, reliable and cumulative way' (quoted in Oakley, Gough, Oliver, & Thomas, 2005: 5). In its place, he wrote, doctors should establish a system of 'evidence-based medicine', in which evidence for the effectiveness of medical interventions should be systematically assessed and form the basis for treatment choices. Cochrane's book was initially targeted at the field of medicine, but his simple message, about the inevitable lim-itation of resources and the importance of using evidence from research to estab-lish which approaches are most effective, quickly caught on. His work led to the opening of the first Cochrane Centre in 1992 and the founding of the Cochrane Collaboration (www.cochranecollaboration.com) in 1993. By then his ideas were influential across the whole field of social care and mental health; and the impact of his ideas has continued to broaden out even further in the last 25 years to cover almost every aspect of public life.

While Cochrane's ideas have been hugely influential, what is less well-known is why he first developed these ideas. In his autobiography, Cochrane describes how, as a young medical officer, he was captured by the German army, and found himself in a prisoner of war camp in the early 1940s, caring for a motley group of prisoners of various nationalities, many of whom were suffering from tuberculosis. Cochrane and his colleagues attended to the men as best as they could, herded together behind a wire fence. However many of the soldiers whom he cared for, and came to think of as friends, did not survive, and Cochrane found himself taking the role of priest as much as physician. Looking back many years later, Cochrane remembered a day when he found a propaganda pamphlet which had been dropped inside the camp, championing the 'clinical freedom and democracy' that would be achieved if the Allies were to win the war. Recalling this experience, Cochrane wrote:

> I found it impossible to understand. I had considerable freedom of clinical choice of therapy: my trouble was that I did not know which to use and when. I would gladly have sacrificed my freedom for a little knowledge. I had never heard then of 'random-ized controlled trials', but I knew there was no real evidence that anything we had to offer had any effect on tuberculosis, and I was afraid that I shortened the lives of some of my friends by unnecessary intervention. (Cochrane, 1972: 6)

This uncertainty about the knowledge-base for his medical practice stayed with Cochrane after the war, and resulted many years later in the publication of his book on evidence-based medicine. Cochrane never wanted doctors to face the situation he had himself faced as a young man, in which he risked shortening his patients' lives because of his lack of knowledge about appropriate methods of treatment. If evidence could be accumulated from lots of doctors, about lots of treatments for lots of patients, perhaps this body of knowledge could be used to improve the chances for patients – or at least it might make his decision-making better informed than he had been when relying only on the trials and errors of his own medical career.

The limitations of research

Of course, there are many good reasons why child therapists should be wary of research findings (Cooper, 2008). For a start, research talks mostly in generalities rather than specifics. So, for instance, a research study might show that depressed clients, on average, will improve with cognitive behavioural therapy, but this does not mean that a specific individual, such as Talia, will find benefit in this approach. The probability is that she will, but she may not, and it is also possible that she will feel a lot worse after it. In this respect, to base therapeutic practice wholly on empirical research findings – to the exclusion of other factors, such as the expressed preference of the young person – would be profoundly unethical. Counselling and psychotherapy research findings can only ever tell us about what is most likely to happen – they cannot give us certainties.
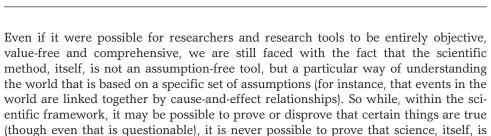
Then there is the problem that research findings cannot fully capture the complexity of what happens in the therapeutic process. They are necessarily reductionist and approximate. An outcome measure is, after all, a standardized questionnaire that tries to capture change in a numerical way, but it cannot tell us the meaning of that number. Talia, for example, two sessions in, may actually report feeling sadder and more tearful than when she started therapy, because she is starting to realize that behind her anger, she really misses her nan. This may make her score on an outcome measure look the same as when she started, or perhaps even worse. Does this mean the therapy is not working? Not necessarily. And it may also be, for instance, that Talia is having fewer arguments with her mum, but the form she is filling out does not ask her much about this, and so there is no box to tick. And when she is asked to fill out a different form, this time about something called the 'alliance', her score is in the moderate range, suggesting that her relationship with her therapist is neither strong nor weak. But, again, this does not capture the reality: that sometimes Talia feels so close to her therapist that it is just like talking to her nan again; but then, when her therapist is too 'bossy', she just reminds her of her mum and Talia just wants to get out of there.

Another limitation of research findings is that they will inevitably be influenced by the researchers' own assumptions and biases. That is, even when research is conducted in a highly rigorous way, biases still manage to creep in. From the research question or topic, to the methods employed, to the way findings are written up, choices are being made by people (researchers) who live and work in a particular social, cultural and political climate. This means that we should always read research findings in a critical way, paying attention to the background and context of who conducted the research and what their agendas might be.

Research findings are also always arrived at through the use of some particular tool, measure or procedure, and these will inevitably influence the kinds of findings that are reported. (Indeed, even the word 'findings' suggests that what the researchers report was just sitting there, waiting to be 'found', rather than the reality that is that evidence is always constructed, at least to some degree, by the way the research team has framed their investigations.) If psychological wellbeing is defined and measured in terms of an absence of mental illness, for instance, the kinds of therapies that are shown to be most effective may be different to those where it is defined and measured in terms of a potential for growth. Researchers can even come up with radically different conclusions from the same set of data if they use different tools of analysis. It is also important to bear in mind that research is always conducted with a particular sample of people, such that the generalizability of its findings will always be limited.

Even if it were possible for researchers and research tools to be entirely objective, value-free and comprehensive, we are still faced with the fact that the scientific method, itself, is not an assumption-free tool, but a particular way of understanding the world that is based on a specific set of assumptions (for instance, that events in the world are linked together by cause-and-effect relationships). So while, within the scientific framework, it may be possible to prove or disprove that certain things are true (though even that is questionable), it is never possible to prove that science, itself, is the 'truest' way of understanding the world.

Another reason why therapists can be critical of evidence-based practice is because it can be experienced as a devaluing of professional competence, insofar as it can lead to assertions that 'young people presenting with X should be offered Y because the evidence-based guidelines say so'. When coupled with decision-making by commissioners of a similar sort (i.e. 'We won't commission X because the guidelines say that Y is the best treatment for Z'), it is not surprising that evidence-based practice often meets significant resistance in the workplace, where it is sometimes regarded as an inflexible system that over-rides the important local contexts in which decisions are made in response to complex situations. At its worst, there is a danger that evidence-based practice may lead to a rigid, unthinking system that works against the very aims that it strives for – to improve outcomes and the quality of care. The gap between research and practice – between evidence-based practice and evidence-based practitioners – is at risk of being maintained.

The value of research

Research findings, then, are by no means an infallible guide to practice, but they can still be of enormous help in day-to-day clinical practice (Cooper, 2008). For a start, they can give therapists some very good ideas about where to start from in the absence of other information. Research can only ever tell us about the likelihood of certain things happening, but that knowledge can be enormously valuable when integrated with other sources of knowledge to inform our decision-making.

So, for instance, Talia's therapist may find it very helpful to think about the way in which this young woman relates to her and others in terms of 'attachment', and whether Talia's somewhat 'dismissive' pattern of relating is associated with her early experiences of care-giving. As discussed in Chapter 3, attachment research, along with research in early parent–child interaction, can give a helpful framework to make sense of how a child or young person has come to experience difficulties. Similarly, research on the process and outcomes of therapy can function as a very helpful guide to practice. So, with Talia, it could be useful to know that both sadness and anger are typical features of depression in adolescence, and to be able to draw on guidelines that indicate which kinds of therapy have been most successful with young people suffering from depression. Or, at a more micro level, it may be helpful to find out what research suggests about specific therapeutic techniques. For example, Talia's therapist may benefit from knowing that research studies have suggested that problem-solving techniques are generally helpful with depression, but that it is essential to establish a good therapeutic relationship before launching into tasks and techniques. She may also find it helpful to know that this relationship is best built by a child or young person having control over the pace of therapy. This is not to say that those

research findings will necessarily apply in Talia's case. Her therapist may discover that Talia actually dislikes problem-solving techniques, but until the therapist has a clear sense of what that particular young person wants or needs, the research evidence can provide a valuable source of guidance on what might be useful.

Research findings can also be very helpful in encouraging us to critically reconsider our assumptions about what works and does not work in therapy. For instance, we may assume that the best way to help Talia is to focus on her and get her to talk about herself rather than other people. But, as will be discussed in Chapter 6, there is evidence that giving young people time to talk about their relationships with their families can be more helpful than a solely 'internal' focus. This does not mean that asking Talia questions about herself are going to be unhelpful, but it may make us think about whether to balance our questions about Talia with some enquiry about the other important people in her life. In this respect, research findings can help us be more open to the myriad ways in which children and young people may be helped in therapy. At best, research can broaden our ways of thinking, introduce new perspectives, and encourage us to adhere less rigidly to one particular set of choices.

Within the world of contemporary healthcare practices, there is another very good reason, albeit a more pragmatic one, why child therapists should be aware of the research findings: to communicate to others about their work, and to help families (and commissioners of services) understand the value of what it is that they do. Today, it is rarely enough to say to a commissioning agency, 'I really think you should employ me because *I* know that what I do is helpful.' And why should it be? Funding bodies, whether large-scale organizations or private individuals, are becoming increasingly critical consumers, and want concrete evidence with which to justify their expenditures. So with so much high-quality evidence demonstrating the value that therapy can have, it would seem entirely self-defeating for therapists not to have a good working knowledge of this evidence. As the research itself shows, counsellors and psychotherapists tend to underestimate the strong research support for certain positive therapy findings (Boisvert & Faust, 2006), so knowing what the research really says can help therapists feel more confident in promoting their work.

Developing this book

Given these arguments, this book is written from the perspective that research is an invaluable component in the training of therapists for children and young people, and that it is important for us all to develop a level of *research literacy* in our everyday practice. By 'research literacy', we mean both the capacity to read and understand research studies, but also to be able to evaluate them critically, to understand their limitations as well as their strengths, and to make use of their findings in a judicious way. Such literacy is not straightforward, especially when much research is written in an impenetrable academic style that often makes it hard for the lay-reader to follow the points being made. Furthermore, the sheer amount of research being published month-by-month makes it almost impossible for busy therapists to keep up with the latest findings, or to be aware of any but the most high-profile studies.

It was with these issues in mind that we decided to put together this book. While recognizing the impossibility of being entirely comprehensive, we wanted to ask

experts in their fields to try and bring together the key research findings in their area, summarized in a form that would make sense to therapists working with children and young people, and making clear what the potential significance of these findings might be for our practice. The basic template for this book was Mick's *Essential research findings in counselling and psychotherapy: The facts are friendly* (Sage, 2008), which strove to achieve something similar in the adult therapy field. As with Mick's original text, although our focus is on the findings themselves, we hope this book can also help to de-mystify the process of research itself, both by providing explanations of key research terms and giving examples of how particular studies came to the conclusions they reached.

The position we have taken in this book is explicitly pluralistic, in two particular respects. First, it is pluralistic in regard to the kinds of research that we believe are of relevance to child counsellors and therapists. There is a danger that the term 'research' can sometimes be used too narrowly to refer only to outcome research, or research evaluating the effectiveness of a particular type of therapy. Although we have included chapters on such research in this book, we believe that there is a much broader range of research that is relevant to clinical practice. For instance, we have chapters that review key findings from epidemiological research, as well as developmental and neuroscientific research, and research examining the process of psychotherapy.

Our approach is also pluralistic in regard to the types of research methodologies that have been used in the studies that are discussed. Rather than thinking in terms of a hierarchy of evidence, in which randomized controlled trials are better than, for example, qualitative research studies (see Chapter 4), we believe that different questions can be best answered by using different research designs. The chapters in this book therefore draw on a wide range of research methodologies and, partly for that reason, they may sometimes reach somewhat different conclusions. As a reader, this has the potential to be confusing, but it is the nature of research, and an important reason why we need to be both cautious and critical in the way we interpret research findings. No research findings are 'objectively' true, and for each study we must ask ourselves how it came to the conclusions it reached, and to what degree those conclusions may carry over into other contexts.

Overview

This book has six main chapters. Following this introduction, Ann Hagell and Barbara Maughan look at the epidemiology of child mental health (Chapter 2), i.e. the extent to which children and adolescents experience mental health problems, and the various factors associated with higher levels of distress. Chapter 3, by Graham Music, then looks at some of the key developmental factors that can cause mental health problems in children and young people, with a particular focus on neurobiological and attachment-related processes. Chapter 4, by Terry Hanley and Julia Noble, reviews the evidence for the effectiveness of counselling and psychotherapy with children and young people, overall. This is then broken down in more detail in Chapter 5, by Peter Fonagy, Liz Allison and Alana Ryan, who focus on the specific types of therapy that have been found to lead to positive therapeutic outcomes for children and young people with a range of specific psychiatric diagnoses. In Chapter 6, by Jacqueline Hayes, this exploration is developed further,

by looking at the other factors – such as the quality of the therapeutic alliance – that are associated with positive therapeutic outcomes. Finally, Chapter 7, by Jacqueline Hayes and Clare Brunst, looks specifically at the evidence for particular techniques and practices in therapy with children and young people. The last chapter of the book, our Conclusion (Chapter 8), aims to draw the research findings together. Finally, we present a Glossary to help define and clarify the research terms used throughout this text, which we hope child therapists will also find useful when reading other research papers.

Although this book aims to give an overview of research findings in therapy with children and young people, there are inevitably gaps and omissions. For example, Graham Music's review of the developmental research in Chapter 3 does not cover all aspects of child development (for instance, cognitive development), as this would be a book (or a series of books) in itself. His chapter focuses primarily on neuroscience, genetics and attachment research, as areas with great potential to inform therapeutic work with children. Likewise, as most outcome research has been organized around specific psychiatric diagnoses, Fonagy et al.'s chapter does not review evidence for problems that fall outside of specific diagnostic categories (for instance, bullying). Furthermore, the research in all of these fields is developing rapidly and, even as these chapters are being written, new research findings are being published that may revise what has been written. In our concluding chapter, we discuss some of the ways in which therapists working with children and young people can try to keep themselves updated with key research findings – without having to give up their day-job and spend the whole time reading journals!

The structure of the chapters

In editing this book, we have tried, as far as possible, to draw the chapters together into a single unified text. We were also very mindful that many counsellors and psychotherapists may have limited training in research methods; and that research – like therapy – has its own set of specialist language which is not always clear to non-specialists. Hence, we aimed to achieve certain features and standards across all of our chapters, and asked our authors to take on a particular set of challenges. First, that the writing should be engaging, accessible and stimulating, such that readers would be interested enough to engage with the ideas being presented. Second, that wherever possible the language should be non-technical, jargon-free and direct: accessible to readers who have minimal knowledge of research methodologies or psychology. (Where research terms are used, we have provided a Glossary at the end of the book, and have highlighted the term in bold when first used in a chapter.) Third, that the research should be presented in a non-partisan and open-minded way: one that is able to stand back from any particular orientation or perspective and give a relatively balanced overview of what we know. Fourth, that the text should be written with a spirit of inclusivity and genuine discovery, such that readers from all perspectives will have a faith in the findings that are presented. Fifth, that the text should be based on a comprehensive, in-depth review of research findings in the area under exploration (qualitative as well as quantitative). This might be through a review of primary sources, or through drawing on systematic reviews and meta-analyses where

relevant. Sixth, that readers should be given some indication of the certainty of the findings and conclusions presented: Are these things that we can be relatively sure of, is there some uncertainty surrounding it, or is it really only indicative at this stage?

Although there are inevitable differences in the style of each chapter, we have also tried to keep certain things consistent throughout the book. In terms of structure, each chapter begins with approximately four to eight bullet points describing the content of the chapter. This is followed by an introduction which sets out the focus and the significance of the chapter topic. Following the conclusion of the chapter, there is a series of bullet points giving a summary of key findings (except for Chapter 5, where key points are drawn out throughout the chapter). Recommended reading is also given at the end of each chapter, with an annotation for each text explaining why this might be of interest. Every chapter ends with three to six questions for reflection, which invite the reader to consider the key points raised in the chapter. At relevant points in the chapter, there are also sections on implications for practice, which draw out clinical implications of key findings; and chapters also include sections on gaps in research knowledge. These identify areas of counselling and psychotherapy with children and young people where there is insufficient evidence. This not only highlights the ongoing nature of research, but may also be a spur for trainees looking for ideas for their studies.

Difference and diversity across the chapters

As the readers will see, there remain some differences across the chapters and we wanted to allow our authors free reign to write from their particular standpoints.

One particular issue that faces all researchers working in this field is the question of psychiatric diagnosis. Many counsellors and psychotherapists working with children and young people have strong views about the value (or lack of value) of using psychiatric diagnoses, and a number of our chapter authors touch on this issue. However in some fields (such as epidemiology, or treatment outcome studies) almost all of the research to date has been organized in relation to specific psychiatric diagnoses, so that any summary of findings has to follow such a structure. Inevitably there are limitations to this, and in other chapters (such as the chapters on the process of effective therapy) research is not always organized around such diagnostic categories.

There are also some differences in terminology, and although we have tried to standardize methodological terms across the text, we wanted our authors to use the terms they were most comfortable with. Hence, while some of the chapters refer to 'patients', others refer to 'clients'. Equally, some chapters talk of 'treatment' while others use less medical terms such as 'therapy' or 'counselling'.

Throughout the book, we use the term 'child therapy' to cover the wide range of counselling and psychotherapy approaches with children and young people, unless we are describing a study that specifically focuses on one type of counselling or psychotherapy. Likewise, we use the term 'children' to refer to those younger than 11 years, and 'young people' or 'adolescents' to refer to those aged 12–18 years. Where a research paper that is quoted by an author covers ages that are outside these brackets, it will give the age of the study participants. We do not cover research on therapy with parents and infants (under 2 years).

Reflexive statements

Given that, as discussed above, research findings always reflect the biases of their source, we thought it would be useful to finish this introduction by saying something about where we are coming from as editors of the present text.

Nick

I trained as a child psychotherapist at the Anna Freud Centre in London, and was part of the first year-group where the training became part of a professional doctorate at UCL, and so included teaching of research methods and the requirement to carry out a research dissertation. With a background in English literature and the arts, this at first seemed a very alien world to me, and I struggled to get my head around statistics and to see how research and clinical practice could relate in a meaningful way. I was very fortunate to have as my mentors Profs Peter Fonagy and Mary Target, who both embody a commitment to the systematic examination of clinical ideas, not only in regard to treatment outcome, but also in using developmental research to inform the development of clinical practice.

My own doctoral research was supervised by Mary Target, working on a study exploring the long-term follow-up of child analysis, in which I carried out a qualitative analysis of interviews with adults about their memories of being in therapy as children (Midgley and Target, 2005; Midgley, Target, & Smith, 2006). When I started on my research project, I remember that I was struggling as a trainee therapist to work with one particular child in foster care, who kept asking me why he had to come to therapy. At first my tendency was to turn this question back to him, and try to explore why he thought he was coming; but at times this simply enraged him. When I began work on the research project, I was struck by how several of the adults we interviewed about their memories of therapy said that they never really understood why they were taken to therapy as children, or why the sessions happened in the way they did. This was something that had stayed with them for many years, and which they still had strong feelings about. Reflecting on this in my research led me to develop a more open approach in therapy, one in which I always checked out why children thought they were coming to therapy (one recently told me that he had been told he was going to see a dentist!), and I became more confident about sharing my own thoughts and perspectives with the children I work with, and helping them to see – and be curious about – what was going on inside my mind when I said or did certain things. This study also led me to wonder about how other therapists might work with a similar challenge, and before I knew it, I found that systematic curiosity about clinical practice (i.e. research) had become embedded in my very way of being, and has shaped all that I have done in my professional life since.

Jac

As a young person I went to counselling after experiencing a sudden and life-threatening neurological illness, and being quite shell-shocked about re-entering the world of 15 year olds at school doing their GCSEs. This first experience of therapy had helpful elements but also reinforced some of my heightened state of confusion –

looking back I realize there was a lot that was unsaid between me and the therapist, who I experienced as quite cold and detached – I left feeling I may have wasted her time and she probably had kids with 'real' problems to deal with. As an adult I worked in the psychiatric system and then trained in person-centred therapy, and later cognitive behavioural therapy. Although my interest in various therapies remains, my congruence as a therapist lies with person-centred values. As a researcher, learning about the history of psychology, the philosophy of science, and then being involved in hearing voices (sometimes known as verbal hallucination) research, has taught me to be wary of taking any findings out of context, and to never be quick to label. This education has also told me that the medical model of psychological problems is just one hypothesis among many, and I prefer to define problems, including those that children and young people face, as 'problems of living' and talk about them in their more everyday sense – 'bullying', 'divorce', 'relationship with father', 'feeling sad'. In terms of research methods, I do have favourites and these usually include those that capture therapeutic processes in real-time, such as conversation analysis.

Mick

I trained initially in person-centred therapy, and then went on to study as an existential psychotherapist. So my practice and writing has always had a strongly relational emphasis, and I've been more wary of highly technical practices. I have also tended to be fairly ambivalent towards psychodynamic therapies. In part, this probably comes from my own experiences as a young person in psychoanalytic psychotherapy at the Tavistock Institute, where I felt that the analytical focus on the here-and-now relationship overshadowed my desire to get some direct help and practical support. I also tend to prefer approaches that emphasize a mutual, dialogical relationship, as opposed to those in which the therapist is the 'knower' and the client 'the known'. Having said that, as Nick indicates, I am aware of the many moves within the psychodynamic field towards more relational practices, and ones that place increasing emphasis on shared decision-making with children and young people. I find these developments very exciting, and strive to be open to a wide plurality of therapeutic approaches (see Cooper & McLeod, 2011; Cooper & Dryden, 2016). In terms of research methods, I am also fairly pluralistic in my views. However, through writing and researching the original *Essential research findings* book, I did find myself increasingly drawn towards research with clear pragmatic implications. That is, research that simply said things about what helped or did not help clients, even if it was coming from a positivist, mechanistic standpoint.

Conclusion

Talia has begun to talk. Awkwardly and uncomfortably, but she has said a bit more about losing her nan, how it really upset her, and how she finds it difficult to talk to people about what she feels. She doesn't like people, she says. They're always interfering – never really listening to her. Her mum is the best example of that, says Talia, criticizing and complaining. But she goes on to say that maybe, perhaps a bit,

she can understand why her mum's always been so angry. Her dad was violent, and when he finally left, Talia knows her mum had so much on and 'not much of a life'.

A few days later in supervision, Talia's therapist reflects on how to help her take the work forward. It feels like supporting and encouraging Talia to talk about her family members is helpful. It seems like the warmth of the therapist is supporting her to open up. The therapist also talks through some other ideas that might be useful for Talia: problem-solving, supporting her to take the lead in therapy, and making sense of Talia's way of relating in terms of her attachment style. Here, as the therapist talks through these possibilities, research and practice, evidence and experience, mix and merge.

Ultimately, the aim of this book is to contribute to the pool of resources that inform your practice: to help you to be able to draw on research findings, as well the many other invaluable understandings, ideas and experiences that you may have. As with Talia, given the complexities and the challenges of the children and young people we may work with, the more knowledge we have, the more we may be able to help.

Recommended reading

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy: The facts are friendly*. London: Sage. Comprehensive review of research findings in the adult therapy field, identifying key domains of research evidence.

Fonagy, P., Cottrell, D., Phillips, J., Bevington, D., Glasser, D., & Allison, E. (2015). *What works for whom? A critical review of treatments for children and adolescence* (2nd ed.). New York: Guilford Press. Definitive review of evidence-based therapies for different psychological problems in childhood.

McLeod, J. (2013). *Doing research in counselling and psychotherapy* (3rd ed.). London: Sage. Concise introduction to research methods and issues in the field.

Questions for reflection

- What would you consider the value, and limitations, of research findings in your own work with children and young people?
- What biases and assumptions about what works for children and young people do you bring to reading this book?
- What kind of research questions would come out of your own experience of working as a counsellor or therapist with children and young people?

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