Introduction to therapeutic approaches

This handout gives a personal view primarily about therapeutic approaches, incorporating some key references, and personal research on consultation and advice (Heywood 2002). It should be read alongside the attached articles on assessment (Eminson 1993, and formulation (Connor & Fisher 1997). My own view is that careful assessment conducted in a style that is acceptable to the family is a key ingredient in the first step of providing some form of treatment or "therapy". The handout therefore is focused on this issue, rather than describing key ingredients of some the mainstream forms of therapy.

Person centred assessment/therapy

There has been a cultural shift away from doctors and professionals being experts and infallible to being sources of knowledge and help. This is set out in the Governments NHS plan. The plan aims to establish "expert patients", and to make records and professional correspondence available. Recent classifications of the type of interaction between patients and professionals include:

- Informed or consumer
- Paternalistic or expert
- Shared or collaborative

Many people with problems will want to adopt an expert stance with the doctor, but some do not, and want to actively participate in decision-making, including the choice to decline, or stop treatment.

Paternalistic approach.

A girl aged 4 is brought to the CAMHS outpatient department with sleep and associated behavioural problems. She is said to be refusing to sleep in own bed, and won't stay upstairs. Parents are asking for help as medication from the GP is not working. They want to know what to do in the first assessment meeting. The professional explains that their problem is common, normal and because the girl has learnt the behaviour over time through the interaction between child and parents. The parents have been inadvertently reinforcing the behaviours by attending to them through understandable reasons. A graded programme of establishing nighttime routine and planned withdrawal with reassurance is proposed. Parents agree to do so.

Shared approach.

Same child with sleep problems. Parents at the first appointment are assertive and state that they want to be involved with the professional in planning what to do to address the problem. Father suggests no change, while mother wants to establish a night-time routine. Father says that he fears psychological trauma will occur if a routine is established, leading to further anxiety and disruption for the child and themselves as parents. This leads to a heated discussion about what is the "right" approach to be used. There is an exchange of information in the consultation with consultant mainly adopting a listening and problem solving approach, suggesting that the parents try to come to a common decision. Information about what works given to parents when requested, and the consultant gives reassurance and an opinion that little long term trauma will occur. She suggests that consistency, and a graded approach is often found acceptable to parents and child. A tentative agreement is reached on establishing a slow graded programme with both parents. Requests for further reading are made by both parents and the professional advises on two books recommending different approaches, with continuing advice that the parents discuss their concerns together to try and reach an agreement.

Informed approach

Same child with sleep problems. Parents want to access information, such as books videos and internet sites about sleep problems and parenting in general. They make it clear to the professional that advice has not been helpful from friends or health visitor or the GP, and that they want to obtain good quality information so that they can discuss what they can do at home. They are interested in attachment problems and whether forcing a child to sleep alone will lead to attachment problems. They want information on the risks and benefits of sleeping alone for a child. The consultant advises on books about attachment disorders, parenting skills and sleep problems. She gives information about attachment problems originating in relationships, and the notion of good enough, rather than perfect parenting. Recognition is given of the cultural norms in the UK of encouraging children to sleep alone. No advice about direct management is given (or requested), and the family are discharged, with their agreement.

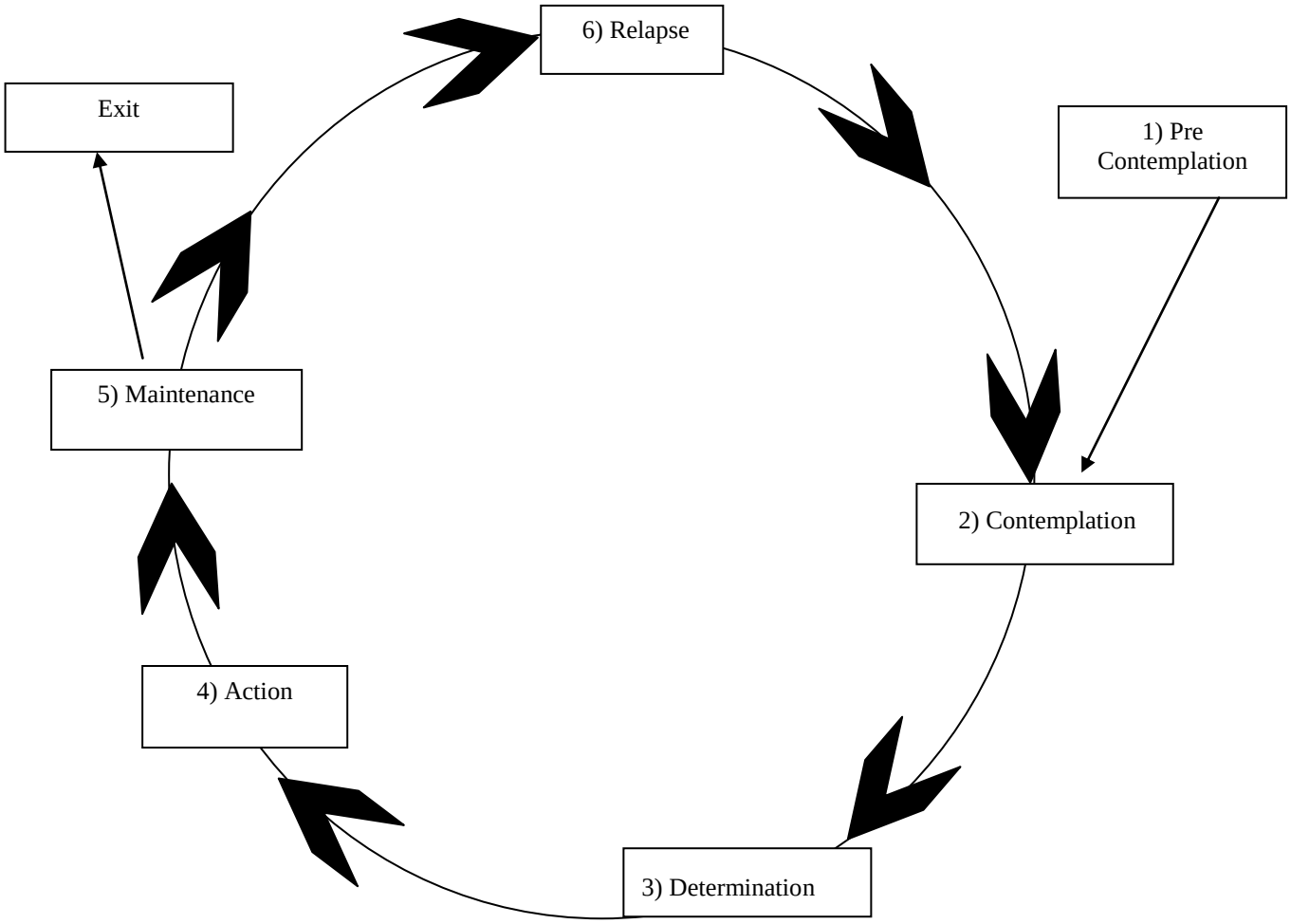
Assessment of user wishes as a driver for change

People visit professionals to find or obtain:-
A cause for the problem
Support from medicine or another service to help with a known problem
Information to enable them to deal with the problem
A prognosis or prediction about a problem

Reassurance that they are doing the right thing about a problem
Reassurance that they are not ill
Evidence that they are ill
An opportunity to discuss other problems not directly related to the presented problem
Treatment for a problem

During assessment or therapy, an important question is how does change actually occur? The trans-theoretical model for change proposed by Prochaska and DiClemente (1992) suggests that the professional has to acknowledge which stage the patient is at when first seen (figure A). Some patients come in a stage of pre-contemplation, where change is not considered. They may however be in an action stage that is proving ineffective. In such circumstances, the patient may be very committed to continue using (or wanting) an ineffective approach (action stage), and not be willing (pre-contemplation stage) to explore or acknowledge possible different approaches. A common example is where people see a GP wanting (and often demanding) an anti-biotic for a cold or sore throat. The doctors may believe that there is no evidence that antibiotics work, and indeed may cause harm if given. Despite this, the patient wants antibiotics, and may think and feel less able to cope if the antibiotic is not given.

In CAMHS as in other medical services, these issues are dealt with on a daily basis, and numerous psychotherapeutic techniques have developed to help families move from a pre-contemplation to contemplation stage. For instance, in family therapy, ideas of narrative, curiosity and social constructivism have been proposed; while in individual cognitive behavioural therapy the therapist aims to establish a collaborative approach to develop a focus for work.



Professional centred assessment/therapy

The approaches used in assessment by CAMHS professionals are drawn from the diverse theoretical and professional knowledge bases, such as biomedical, family systems, social learning theory and psychodynamic, operating within multi-disciplinary CAMHS teams. Hence, there is variability in the way CAMHS professionals approach and conduct their initial assessment. However, what many of these traditional approaches to assessment have in common is that assessment is viewed primarily as a process of gathering information about the child, the family and the presenting difficulties in order to arrive at a clinical judgement about the nature, cause, likely course and treatability of the problem. Ultimately, assessment is seen as a means to an end, that is, case formulation and intervention. Although traditional approaches to assessment stress that the process should also be seen as the first stage in establishing 'treatment alliance'

Drivers of change in assessment/ therapy

1) Assessment of need.

A common definition of a need is the ability for the need to benefit from health care. Patients may want a certain type of help, but may or may not demand it during the first session. In addition within a family there may be many different views about these demands and wants. Individuals within a family can thus be viewed to have different perceptions of need that may or may not be explicitly stated in the assessment interview. The family's differing perceptions of need may not necessarily match the view of the professional. The professional will form an opinion about the need for health care of the family. This will depend on a number of factors including

- The professionals
- Current help being offered for each problem
- Whether the help is effective in reducing the severity of the problem
- The professionals underlying beliefs about what works for the presenting problem, (the evidence base)
- Whether the family is willing to accept the help that will be proposed
- Whether the resources are available to offer this help within or outside of the CAMHS service.

Thus the professional uses expertise and knowledge to assess needs from multiple viewpoints and makes a decision.

2) Assessment and management of risk.

A particular duty of professionals is the assessment of risk; the risk people within the family pose to each other and to others outside of the immediate household. Self harming behaviours are common presented problems, but other forms of harm, such as abuse, and reckless behaviour by adolescents (sexual, or substance misuse) may not be mentioned. The consultant may have to gather such information, both from direct questioning, by observation, and from others involved. Managing risk becomes a task for the family and other professionals with and without statutory responsibility. Contextual factors that alter risk include social or family support, or support from agencies. Clinical factors affecting risk include the level of depression or psychoses. In some circumstances where the risk of harm is high, care proceeding may be necessary, even if this is not perceived to be necessary.

3) "Fit" between Consultant and Family

The consultant's skill lies in finding a way of deploying their expertise and specialist knowledge, from whatever theoretical model they derive in a form that both meets the family's needs and fits with their expectations. Moreover, the challenge to the consultant is to make their intervention useful and meaningful to families. Hence consultations would be judged as 'successful' if the user rated them as holding promise or hope. Consultations are custom-built but in general they lead to common categories or classes of outcome for the family: -

1. An explanation of, and a reflection on, the cause of the problem(s) with the family but with no specific advice.

   The decision for the consultant here is how and when to make their opinion explicit to the family. If asked by the family for a professional opinion, the task is then to deliver it so that it promotes new insights and possibilities without inducing blame or guilt.

2. Advice giving and guidance, in order to enable a family to use their own strengths to deal with the problems. Advice may include written material such as self-help literature.

As with opinions, advice giving requires the consultant to make fine judgements about appropriateness, timing and acceptability. Moreover, families may arrive with particular priorities and agendas about the type of advice they want. For instance, some parents arrive armed with specialist knowledge about CAMH problems obtained from the Internet, which can add to the complexity of advice giving and creating challenges for us as consultants.

3. Signposting to, or referral on to, an external agency.

4. Referral on to a specific treatment or assessment programme (e.g. a specialist form of therapy or multidisciplinary assessment / treatment).

The family's experience of the assessment is critical in determining dynamic outcome. If the style and content of the assessment does not match with the hopes and expectations that families bring to their first appointment they may not want to return. Moreover, it is likely that the family experience of the initial assessment affects the quality of any subsequent engagement with therapy, which, in turn, predicts clinical outcome. In sum, the way that CAMHS specialists approach assessment matters and therefore it warrants greater attention and should be theorised and researched with more vigour.

Assessment versus therapy

Effective assessment may contain similar features with effective therapy. According to Bateman & Fonagy (2000), effective psychotherapeutic treatments contain seven common features: -

a) A clear structure
b) Effort is put into enhancing compliance with treatment
c) They have a clear focus
d) They are theoretically highly coherent to professional and patient
e) They are relatively long term
f) They encourage an interpersonal relationship, allowing the therapist to be relatively active rather than passive
g) They are well integrated with other services

Compare this with our definition of the ingredients of a consultation and advice service (Heywood et al, 2002):

- Brief and focused
- reflects on the process of referral
- elicits parental expectations and wishes
- identifies and works with any ambivalence or blame
- assesses severity and need
- negotiates clear and realistic goals for the consultation
- agrees realistic goals for any therapeutic intervention that may follow the consultation
- attempts to demystify the process of therapy and avoids 'missions impossible'
- allows families to 'opt in' with 'informed consent' to therapy
- avoids 'drifts' into therapeutic relationships and 'therapy by stealth'
- Initially, take a non-expert stance with the family.
- Assess whether the family want or need therapy.
- Assess whether there is agreement between family members.
- To think about patterns of discourse used by the family and by the consultant.
- Be alert to the emergence of issues pertaining to risk.

This can be reduced to the following four tasks: (Street and Downey 1997)

1. Develop an interactive understanding of the referral process
2. Develop an interactive view of the problem
3. Understand the family's ideology of the problem
4. Ascertain the family's expectations of the consultation and consultant

This process will be described in more detail, including some examples.

1) Develop an interactive understanding of the referral process

Initially, we would be asking the family about how they came to be referred to the service, (without necessarily asking for information about the nature of the problem) with questions such as, "Who suggested you should

come to this service?" and "What did the referrer say was the reason s/he was referring you?" This helps to develop an understanding as to whether there are discrepancies between the referrer's concept of the problem and the family's notion of what is wrong, and to elicit any early indications of the family's hopes and expectations. The following example illustrates how this might occur.

Example 1

Cons:	So in terms of ending up here, how did that happen? Without going too much into the problem, how did you end up coming to our service?
Mo:	Well basically I had a word with the Educational Psychologist and asked him if there was anywhere that we could go to, to discuss some things, so he just referred us to here.
Cons:	So, he referred you here to discuss things, OK. Did he tell you anything about our service and what we might do? Did he give you any information about it?
Mo:	Not really, not really no, no.

In this part of the consultation, we are interested in hearing the story of how the family's difficulties resulted in a referral to CAMHS and gathering information about the nature of the problem and the family background. Furthermore, the consultant should try to develop an understanding of how other professionals 'fit' (i.e. whether the family have had any previous professional experience, whether there is any current involvement and a notion of how they came to be referred).

Some families are anxious to tell the therapist immediately about their problems but the skill of the consultant is to obtain the story within the context of the referral process. The following example illustrates how the therapist tries to resist prematurely engaging in a detailed description of the problems and attempt to expand on their understanding of the referral process.

Example 2

Mo:	Well we decided to come, didn't we, as a family because of just the situation at home, which is disruptive. There's not a day go by where we don't have arguments. I feel as though I need to tell Susan that it's also for me as well, so I can help her because she can get me into such a state, where I end up screaming and I bring myself down to her level. So we agreed that, you know, we'd come and try and sort it out, because basically we're happy aren't we?
Cons:	So, how did you come to agree that you would try and get some help from outside the family?

The benefits of 'slowing down the action' in the early stages of the first session to reach a better understanding of the referral process are illustrated in the following exemplar.

Example 3

Mo:	Billy will kick things, people, scream, shout, go upstairs and bang his feet.
Cons:	Right, so you're feeling that things were getting more and more difficult- harder to manage-is that right?
Mo:	Very much
Cons:	And did you talk to your G.P. about that?
Mo:	Yes
Cons:	And how did the idea of coming to see us come about?
Mo:	It was my GP who suggested it. She asked how Billy was getting on when actually I went to see her because I got very depressed about it. And still am. She said there's nothing physically wrong and have you thought of going down *this* road, you know. Which I must admit, I didn't really want to do because I felt, well, that means I've totally lost it.
Cons:	So your GP made you feel that you'd completely lost it and when she suggested coming to see us it sounds as if it made you feel, well, maybe things are worse than I thought - is that right?
Mo:	Yeah

2) Develop an interactive view of the problem

Once the consultant has a better idea of how the family came to be referred to the service (and thus whether they are, in solution focused therapy terminology, pre-contemplative 'window shoppers' or 'browsers' or have definite designs on therapy, and are therefore active 'customers', (DeShazer 1985)) , it is then important to listen to and understand the family's view of the problem. By listening and reflecting, the family has, perhaps for the first time, the opportunity to 'hear' their 'story' told by the consultant. It can be useful to read out the referral letter as this helps to focus 'problem description'.

At this stage, families frequently want to give all the details, often rapidly, to the consultant, which can make it difficult to intervene. One way of slowing the process down is to check out with the family your understanding and to repeat back their version of events. It is useful to take an example and follow it through so the consultant begins to develop a 'behavioural understanding' of the problem. That is, with the family's story about their difficulties, together a picture of events develops. Use phrases such as, "So you've told me that incident B happened after incident A, so what happened next?" and "Have I got this right…?". The next example illustrates this.

Example 5

Mo:	It's a constant battle really from the moment he wakes up.
Cons:	Would it be a good time for you to try and describe something that happened recently, like this morning 'cos that would give me a better idea of what it's really like at home
Mo:	Right, yeah this morning Rob just wouldn't get out of bed and sometimes he does that. He seems to think that school will wait, everybody will wait for him.
Cons:	So what did you do when Rob wouldn't get up this morning?
Mo:	I just came downstairs and then went up and shouted out 'Well I'll just go without you' and then he suddenly came down screaming at me.
Cons:	Oh right, so things build up then from Rob not wanting to get out of bed, and this doesn't happen every day, but when it does you get frustrated and angry trying to get him up and then Rob gets angry with you and ends up telling you off, is that right?
Mo:	Yeah

3) Understand the family's ideology of the problem

As we have stressed the stages of consultation are not discrete and tightly structured, therefore the family's ideology of the problem can emerge at any stage point in the process. Thus the consultant must be alert to this and prepared to take note and, if necessary, develop implicit references to parents understanding of causation at any point in the consultation. An illustration of family ideology unfolding when the consultant is engaged in reaching an interactive understanding of the referral process is apparent in the following extract.

Example 6

Cons:	So where did the idea of going to see your GP come from?
Mo:	Well we were seeing Dr A because Daniel had chest problems. We thought he had asthma, but we've been down that road and he hasn't and he's also come off Ventolin, which I believe, and I've looked further into it, can cause aggression in children you know.
Cons:	Right, so have you noticed any changes since Daniel stopped taking it?
Mo:	Well he only came off it last week and he's been quite calmer. It's a bit of a coincidence because he started on it last summer when his behaviour started to go from bad to worse
Cons:	Right, so its only been a few days then since he stopped taking it but you've noticed a difference and you think it might be that his behaviour has been affected by the medicine
Mo:	It might not be, it might just be coincidence
Cons:	Right, so if we go back further than six months then to before Daniel was taking the Ventolin were you having any of the aggressive 'flare ups' that led you to see your GP?
Mo:	Yes, but they weren't as bad or as often as they have been recently

In the somewhat idealized, neatly sequential version of consultation depicted for the purposes of this manual, having gained significant detail about the problem and its impact, it is important to understand the meaning the problem has for the family and how they make sense of it. So, we would ask how the family explain their troubles to themselves, explore any theories they have, and what theories they think significant others have. This questioning also gives the consultant an opportunity to identify how well equipped the family are to deal with the problems and perhaps to normalise the situation, e.g. ask how the parent thinks other people in similar situations might deal with it.

Often, there are significant others involved in the child's 'problem' that may not be able to attend the session. If this is the case, it is helpful to ascertain their view of the difficulties by asking, "How might grandmother describe these difficulties?" or enquiring about possible solutions that may have been suggested, such as, "What has Aunty suggested you do when this occurs?" Asking about previous attempts at solving the problems can bring about conversations that highlight the family's strengths, which may then generate a different way of looking at the problem.

In the process of eliciting the family's causal attributions and explanatory frameworks it is important to: -

- Avoid imposing consultant's meaning or solutions onto the problem
- Remain neutral
- Try and expand families meaning and understanding through summarising, reflecting and questioning

The interplay of these features is exemplified in the following extended extract.

Example 7

Cons:	Right, you've (*to both parents*) told me about a number of things that are troubling you and the ideas that you've had about what might be causing these troubles. So can I just clarify these ideas with you to make sure I've understood what you've told me so far? The main problem is that for you as parents Charles battles with you over everything and it's making the job of being parents very hard work.
Mo:	Yeah.
Cons:	At school he's had problems because he won't sit and concentrate with the rest of the kids in his group.
Mo:	Yeah that's right.
Cons:	The other problem is swearing. And, part of your understanding about these difficulties is that you think he is lazy, in terms of getting his clothes on and the battleground stuff, you know. And the other theory you had (*looks at Father*) was you're not sure how much of it is about how your wife manages Charles.
Mo:	Mm.
Cons:	And by the sound of it you're both unsure about how much of it is about Charles and his personality or temperament-is that right?
Fa:	Yeah.
Cons:	Do you have any other theories or ideas about what might be causing these troubles that we've not talked about so far?
Mo:	Well, yeah, ADD- that's been one thing I mean.
Cons:	Was that your idea or somebody else's?
Mo:	Well, I first talked about it with my health visitor when he was about three. It was mentioned then and he got put into nursery earlier than he would have done. And I'd say really that that was his worse period in my opinion. He's grown out of a lot of his behaviour things.
Cons:	So since that nursery stage, have you become less or more convinced that Charles might have something like ADD?
Mo:	I'm not sure but I think it might be more about him and how I deal with him.
Cons:	So is that what you would like me to concentrate on in our meetings or would you also want me to think about the possibility of ADD?
Mo:	Ideally I'd want you to do both if that's possible.

4) Ascertain the family's expectations of the consultation and consultant

The last exemple introduces the crux of consultation - to explore with the family what it is they want rather than assuming the family want advice, therapy, an opinion, or a theory to aid their understanding. In example 7, eliciting the parents' ideas about causation led directly into an opportunity to ascertain their expectations of the consultant and negotiation of the focus of the consultation. However, if the consultant is attempting to open up the area of family expectation they might begin by asking, "What did you think would happen here today?" or "What had you hoped would happen?" This gives an indication of the family's view of the potential help they might receive. Some say they "don't have a clue", others are clear that they want therapy for their child or advice on how to deal with the problems.

It is often the case that the process of gathering information leaves little room for exploration about what would be most useful to the family. With some families, feeding back a lack of clarity can be useful whereas with others, it could be disastrous. Often families arrive with an expectation that the consultant will 'give' them something - advice or an opinion - and will therefore be disappointed if this doesn't happen. In a more traditional setting, these may be the types of families we 'lose' because they do not attend again. The important difference then in consultation is to discuss their expectations and to think with them about the implications of advice giving.

Once the consultant has established what it is the families expects, rather than simply deliver the goods, part of the consultation process is to have a conversation about the impact of what this outcome might bring. For instance, if the family want advice about a particular problem, ask them "What advice do you think is likely to work?" or "How would things improve if I offered that advice?" or "What kind of advice were you expecting?" This again gives clues as to how the family will utilise the information and may encourage the family to generate their own solutions.

Giving advice can sometimes require tentative and sensitive handling, particularly as many parents attending CAMH services already feel to blame for their children's difficulties. This is perhaps more difficult if the consultant has identified a need for change in a particular area before the family have. When offering advice, the therapist should check out with the family whether they have understood and whether they think that the advice is a useful way forward. This may highlight similarities and differences in opinions between family members.

Advice can also be given in the form of a letter once the session is over, which may include a brief recapitulation of the assessment. The NHS plan suggests that professional correspondence is copied routinely to families and thus, if the therapist does write a letter, it may serve the purpose of informing the GP or other professionals involved. Most of the letters we have written to families have been to summarise the session and the advice given, particularly when one parent is absent from the session. This helps the parent feed back to the other about what they may need to think about in-between sessions.

Some families want to share their concerns about their child's problems and simply need reassurance that either they are doing the 'right' thing or that it is nothing too serious, so they ask for the consultant's opinion. The skill of the consultant is to assess whether this should be delivered at that specific moment or whether further exploration of the parents' views, for instance, would be more productive.

References

Bateman AW, Fonagy P, 2000. Effectiveness of psychotherapeutic treatment of personality disorder. British Journal of Psychiatry, 177, 138-143

Connor DF, Fisher SG (1997), An Interactional Model Of Child and Adolescent Mental Health Clinical Case Formulation. Clinical Child Psychology and Psychiatry, 2, (3): 353-368.

DeShazer, S. (1985) Keys to Solution in Brief Therapy. New York: Norton

Digiuseppe R, Linscott J, Jilton R (1996), Developing the therapeutic alliance in child – adolescent psychotherapy. Applied and preventive psychology 5: 85-100

Eminson DME (1993). Assessment in Child and Adolescent Psychiatry. In Seminars in Child and Adolescent Psychiatry (eds Black D, Cottrell D) Gaskell Press.

Kroll L, Green JM (1997), The Therapeutic Alliance in Inpatient Child Psychiatry. Development and Initial Validation of a Family Engagement Questionnaire. Clinical Child Psychology and Psychiatry, 2, (3): 431-447.

Street, E. and Downey, J. (1996) Brief Therapeutic Consultations: An Approach to Systemic Counselling. Chichester: Wiley.