

The Handbook of  
**Counselling Children**  
and **Young People**

# 12

## Therapeutic Skills

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This chapter includes:

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- Generic therapeutic skills we utilise when working with children and young people rather than describing the skills used in a specific modality
  - A brief review of the research into the types of counselling and psychotherapy interventions which appear to work the best
  - A definition of therapeutic skills
  - An outline of the BACP (2014) Competencies for Working with Children and Young People
  - The argument that active listening is a generic therapeutic skill relevant across modalities
  - Identification of the differences between working with children, young people and adults
  - A discussion of the issue of working briefly
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### Introduction

This chapter focuses on the therapeutic skills we use when working with children and young people. These skills are related both to our knowledge and also our beliefs about what we feel is effective. These beliefs often rest upon our theoretical orientation. So, the first question we may need to ask is ‘what works best?’. This is addressed in Chapter 16 of this handbook, ‘Evaluating Counselling’. However, probably the most

comprehensive overview of research into the efficacy of working with children and young people is to be found in the recently published BACP scoping review on research on counselling and psychotherapy with children and young people by McLaughlin et al. (2013). The study examined evidence from meta-analyses, systematic reviews from controlled trials, cohort studies, case studies, observational and exploratory studies, and 'methodological papers that raise issues for future research in this field' and so gives an exceptional overview of research in this area.

The review builds on the previous scoping review by Harris and Pattison in 2004 and asks the same question: Is counselling and psychotherapy effective for children and young people? Three sub-questions were also explored:

1. Which types of counselling and psychotherapy interventions work?
2. For which presenting problems?
3. For whom?

In terms of techniques, CBT, psychodynamic, play therapy, humanistic therapies and interpersonal psychotherapy were all found to be beneficial, with some approaches seeming more beneficial than others with particular presenting problems.

Contained within the review is a report of a study by Bratton et al. (2005), who conducted a meta-analysis into the efficacy of play therapy. They found that the results were more positive for humanistic approaches and that inclusion of parents in play therapy was associated with a positive outcome.

Part 1 of this handbook explores the therapeutic techniques of these different theoretical approaches, whilst this chapter considers the knowledge and skills that underpin all therapeutic encounters with children and young people, regardless of orientation. It focuses, in part, on the therapeutic relationship and the skills utilised to offer this. Rather than repeat the content of other chapters, the reader is advised to read the relevant chapters to support understanding of this chapter. Chapter 1 is relevant to the discussion of child development and attachment. Chapters 2 to 8 outline different theoretical approaches. In addition, the reader is also advised to read Chapters 17 and 18 when considering law and policy and ethics and Chapter 16 when curious about evaluation.

Lambert and Barley (2001) identified four factors that influence the outcome of therapy: These were:

extra therapeutic factors, expectancy effects, specific therapy techniques, and common factors. Common factors such as empathy, warmth, and the therapeutic relationship have been shown to correlate more highly with client outcome than specialized treatment interventions. (p. 357)

And they suggest that:

decades of research indicate that the provision of therapy is an interpersonal process in which a main curative component is the nature of the therapeutic relationship. (p. 357)

They argue that we need to tailor our relationship to our individual clients, in this case children and young people, and improve our ability to relate to them.

## What Are Therapeutic Skills?

Therapy is a process of relationship building and trust acquisition between the therapist and the client. To facilitate this relationship counsellors need highly developed therapeutic skills. Therapeutic skills are verbal and non-verbal ways of engaging with clients in order to establish an emotional environment where a therapeutic alliance can be created, maintained and safely terminated. This relationship is vital if we are to assist clients in exploring how their life experiences have informed their way of being and, if they choose, find new meanings and ways of relating to self, others and life.

Corey (2001) reminds us that irrespective of one's core therapeutic model, effective counselling skills should be a carefully balanced blend of attention to our client's emotions, thoughts and actions. In this way, we can enable our clients to reflect upon their belief systems, experience the emotional depths of their internal and external struggles and use these to aid new ways of being.

Rather than detail specific therapeutic skills, The British Association for Counselling and Psychotherapy (BACP) have developed a set of competencies for therapists who work with young people. These are available on their website ([www.bacp.co.uk/](http://www.bacp.co.uk/)). These competencies have been developed as humanistic competencies but the core and generic competencies, in our view, detail the general therapeutic skills and knowledge relevant to all practitioners working both with children and young people regardless of theoretical orientation. Some of the issues identified in these core competencies are explored in detail within this handbook, reflecting the importance of these areas when working therapeutically with children and young people.

Competencies identified by BACP (2014) include knowledge of child and family development and transitions, and knowledge and understanding of mental health issues. Knowledge of legal, professional and ethical frameworks is considered essential, including an ability to work with issues of confidentiality, consent and capacity. BACP (ibid.) suggest that therapists need to be able to work across and within agencies and respond to child protection issues. In addition, therapists need to be able to engage and work with young people of a variety of ages, developmental levels and backgrounds as well as parents and careers in a culturally competent manner. They also need to have knowledge of psychopharmacology as it relates to young people.

The generic competencies relate to knowledge of specific models of intervention and practice, an ability to work with emotions, endings and service transitions, an ability to work with groups and measurement instruments and to be able to use supervision effectively. The ability to conduct a collaborative assessment and a risk assessment is paramount. Crucially, BACP (2014) suggest the therapist needs to be able to foster and maintain a relationship which builds a therapeutic alliance and understands the client's 'world view'. In our experience most proficient therapists, irrespective of their modality, work to achieve this trusting relationship necessary for human change. Four broad areas of the therapist's intent within this relationship are described below:

#### Attention-Giving

This is where we actively demonstrate to clients through verbal responses, facial expressions, eye contact and body posture that we are in a supportive, respectful, accepting and authentic relationship with them. This builds respect and trust in the therapist–client relationship.

#### Observing

This is where we observe the client's verbal and physical expressions to enable us to more fully understand our client's experience, their relationship with the therapy process, their life experiences and us. We believe that by noticing these, it leads to greater relational depth (Mearns and Cooper, 2005). This relational depth allows the client to feel safe enough to try out new ways of being, which can be a prelude to trying these outside of the counselling relationship.

#### Listening

This is where we are *actively listening* (Rogers and Farson, 1987) to the content and emotional experience of a client's story, while listening out for indicators of how the client defines their experience. At the same time, we are continuously communicating back to the client that we have heard and understood their phenomenological perspective. Active listening and affirming what we have heard imbues in the client a sense of being understood and accepted.

#### Responding

This is where we are responding to a client's core communication. This involves reflecting the content and feeling of the client's expressions while offering summaries that can lead to further expression or exploration of how the client wishes to move forward from current or historical experiences. This also gives the client the opportunity to modify the internal view of their external experience, as they hear it reflected back to them. As we discuss later in the chapter, the way we respond will need to be developmentally appropriate and may use other mediums of communication such as play.

Although specific orientations, for example CBT, will have specific skill sets, the four broad areas described above are often seen as the basis for therapeutic work with children and young people. Taken together, these four areas can be described as demonstrating the skill of active listening. Rogers and Farson (1987: 1) argue that:

People who have been listened to in this new and special way become more emotionally mature, more open to their experiences, less defensive, more democratic, and less authoritarian.

The fundamental premise is that these therapeutic skills span all client groups irrespective of age, gender, sexuality, cultural background and life experiences. What is key is how we adapt attention-giving, observing, listening and responding to meet the unique needs of the client before us. This is true for all client groups but never more so than for those of us working with children and young people. For younger children, we may adapt our active listening by communicating through play whereas older young people may be more able to tolerate a more adult type of counselling experience.

Rogers and Farson (1987) describe the skills required for active listening. They argue we need to really understand what the speaker is saying from their perspective and communicate that we have done this. When we listen, we have to listen for 'total meaning' – both the content of the communication and the feeling and/or attitude underneath this. We need to 'respond to feelings'. The feelings can be much more important than the content. Finally we must 'note all cues'. This means attending to non-verbal as well as verbal communication and being aware of how something is communicated, hesitantly or confidently for example. Again, we will adapt our skills to the age and developmental level of our client and communicate through appropriate mediums. For work with children, play is often the preferred way of working and this is described in Chapter 7, 'Play Therapy'. Young people and adults can also find play therapy very powerful but may feel it's babyish so age-appropriate ways of working need to be employed. Younger adolescents may find it difficult to tolerate the focused attention of the therapist so a third focus, often creative work, can be offered.

Using age-appropriate mediums will make the communication of active listening more accessible. It is acceptable to be creative and not be fearful of inviting the client to consider working in this way. Chapter 8, 'Other Creative Approaches', offers some ideas and it may also be useful to offer life simulation computer games as a powerful vehicle for the client to express their world. Clients may choose to use mobile phone texting to share some of the toughest experiences they are not able to verbalise. This may require a service phone specifically for this purpose and some pretty fast texting skills on the counsellor's part.

In addition to offering active listening skills which can be viewed as one of the underpinning skills of all interpersonal encounters, there is also a need for the specialist skills that fit with different modalities and relationship needs of the client. Therapeutic

skills when working with children and young people will be used to operationalise the philosophy of the particular modality. Person-centred counsellors will focus on offering a relationship characterised by the core conditions (Rogers, 1951). Cognitive-behavioural therapists will be looking to develop the therapeutic alliance in order to help the client make connections between thought, emotions and behaviour (Beck, 1995). The psychoanalytic therapist will be aiming to develop a relationship in which transference can occur and where unconscious material can be made available to the conscious mind (Corey, 2001).

### What Are the Differences between Working Therapeutically with Adults, Children and Young People?

Although there are similarities between all therapeutic work, there are some important differences. These include:

- Differing stages of development – emotional, moral, physical and cognitive: see Chapter 1 of this handbook, 'Child Development and Attachment'
- Ethical and power issues: see Chapter 17 ('Law and Policy') and Chapter 18 ('Ethics') of this handbook, and Daniels and Jenkins (2010)

Therefore, as has been suggested in the BACP (2014) Competencies for Working with Young People, a knowledge of child and family development is essential, as well as a knowledge of legal frameworks and an ability to work with issues to do with confidentiality and capacity.

Therapeutic skills that enable us to work with adults are not necessarily suitable for work with children and young people. In addition, those suitable for young people (adolescents) are not necessarily suitable for working with children (primary school aged children and younger). Those commissioning therapy for children and young people share this understanding (Pattison et al., 2007). We need to appreciate what separates children from young people and young people from adults, and how having a therapeutically differentiated strategy can be the crucial element in providing safe yet effective therapeutic outcomes. What should inform this strategy is an understanding of the developmental stages young people grow through and which are described in Chapter 1.

Counsellors need to be aware of the significant impact these developmental stages have on childhood understanding and communication and must be willing to adapt their way of work to accommodate these variants (Churchill, 2011). Particular skills in working with children and young people need to be developed. Part 1 of this handbook, particularly Chapters 2 to 8, describe the theoretical base and skills needed for a number of modalities for working in this field.

The key stages of development include physical, emotional and cognitive functioning. These stages are rarely synchronised with each other and we would argue that the chances of them being disharmonious is greater in young people who have suffered early life trauma. This means that many of our clients may present as being under- or overdeveloped physically, emotionally and/or psychologically in relation to their expected stage of development. Client presentations of development will often not parallel each other; a client could be physically overdeveloped and emotionally underdeveloped. The case study is an example of this, the issues it may cause and the skills a therapist may employ to manage this.

Culture may also affect the development of children and young people and how we view their development. The age at which a child becomes a young person or an adult varies from culture to culture and so we need to move away from adopting one static theory of child and adolescent development and select one that can form a 'baseline starting point from which to modify and improve upon so that they maintain their relevance in a rapidly changing multicultural society' (Walker, 2005). He maintains:

We also need to reflect upon our own perceptions and beliefs concerning child development and avoid rigid understandings. We need to ensure that we come from an open, curious and culturally pliable position. (Walker, 2005: 15)

Another difference when working with children and young people is that of boundary keeping, especially confidentiality. Children and young people are, in general, much less autonomous than adults and have several groups of people interested in, concerned for and responsible for their welfare (parents, relatives, carers, teachers, social workers, dinner nannies for example). In our experience, to stick to the normal adult limits of confidentiality can risk alienating the people responsible for the care of the child or young person and may ultimately put them at risk. The carer may feel that the child or young person is sharing 'secrets' that they feel threatened by or that you have an intimate connection with your client that could jeopardise the relationship they have. In order to keep this boundary sensitively, we need to develop communication skills that will allow us tell the carers enough to keep them involved but not enough to violate the child or young person's privacy. Generalities such as 'Things seem to be going well' or 'How are you feeling about the therapy?' may suffice but thought needs to go into what it is OK to say and what not. Supervision can help with these decisions and, if possible, the client should also be involved. Sometimes the client wants you to act as a spokesperson for them to their carers so a careful discussion of what is to be shared is vital.

The mechanics of therapy may also be different when working with children and young people. Adults usually refer themselves for therapy but children and young people may be referred by others, usually carers or teachers. If this is the case, both the client and referrer need to understand what therapy is and the client needs to want to engage. It may

be appropriate to offer a home visit to explain both the purpose and procedure of therapy to both the client and the carer. In the case of a teacher referral, a programme of education and information would ideally have been undertaken within the school.

In our experience, in private rather than school settings, we feel it may be better if a carer could accompany a younger child and wait outside the therapy room as the child may want to leave early. Also, having the carer involved in the practicalities of therapy can help the therapist maintain a positive relationship with them.

As with adult clients, it is important to work and plan for the ending of therapy right from the beginning (Robson, 2008) and, if possible, to include the client in planning the final session. It is also helpful, in our view, to try and finish therapy at a time which would resonate with a normal end, for example, the end of school term.

### Relationship of Personal Qualities or Attributes to Therapeutic Skills

It has been suggested that the therapist needs particular qualities or attributes when working with children and young people (Geldard et al., 2013; West, 1996). These qualities or attributes are conveyed through the use of therapeutic skills. They, and the associated skills, will depend, to a certain extent, on the therapist's theoretical orientation. West's (ibid.) description, although quite dated, is one that would be familiar to child-centred play therapists. She suggests personal qualities should include the ability to

- Relate to, through and with feelings
- Understand and come to terms with what has happened in their own childhood, adolescence and adulthood, including child-rearing and parenting issues
- Work within a child-centred framework
- Communicate with children
- Play
- Work alongside troubled children without being damaged by the children's pain
- Act as an advocate for the children they have in play therapy. (p. 150)

Geldard et al. (2013), working from a more CBT stance, suggest four attributes for therapists:

1. Congruence
2. In touch with own inner child
3. Accepting
4. Emotionally detached. (p. 21)

The final one, 'emotionally detached', may be shocking for some therapists but they do qualify this by saying that this 'does not mean that the counsellor needs to be limp,

lifeless and remote. On the contrary, the child does need to feel comfortable with the counsellor' (p. 23).

Whatever personal qualities or attributes we develop to further our work will be communicated through the use of therapeutic skills. Each modality will dictate what we are trying to convey to our clients and how we use our skills to do that. The use of active listening skills can express empathy and attention giving and are qualities commonly valued by all approaches.

## Working Briefly

Working briefly with children and young people will not necessarily change the skill set employed by the therapist but can put pressure on the therapist to 'solve' the problem rather than concentrating on building a strong relationship with the client. As has been suggested earlier, clients, particularly younger children, can find it helpful to end therapy where a break in their routine would occur naturally, for example the end of a school term. Brief or time-limited therapy may not allow this to happen.

### Case Study Andrew

This case study demonstrates work with a client whose physical development had overtaken his cognitive and emotional development and the skills the therapist used to help her client explore the meaning of his experiences.

Andrew was 14 when he was referred to Liz, his school counsellor. He'd been at his new school only five months after his mother had moved to the area seeking a fresh start after the end of another violent relationship. Andrew had two younger female siblings and none of them shared the same father. Andrew was not in contact with his father but his sisters' fathers kept in sporadic contact. Overall their life had been fairly nomadic since Andrew was about two years old.

Prior to the referral, at least three teachers had reported that Andrew's behaviour was becoming more and more disruptive in class and one teacher had asked that Andrew be excluded permanently from his class, after Andrew had 'faced him off in front of other pupils'.

Other staff and pupils had reported that they found it hard to warm to Andrew and that he had done little to integrate himself into his new school community. Andrew's year head accompanied him to his first counselling session to, as the year head put it, 'make sure he bothered to turn up'.

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The first thing that struck Liz about Andrew was his physical presence. Andrew was incredibly tall and broad for his age and could easily have passed for a baby-faced adult man. Andrew's posture, attitude and general manner was one that seemed to demonstrate nonchalance bordering on arrogance. Liz opened the early stages of her work with Andrew by congruently reflecting the path by which he had arrived at counselling. Liz explained it felt their coming together had been coerced. She disclosed her own dissatisfaction about this, and explained that one of the fundamental tenets of counselling was that it had to be a voluntary process that both parties wished to freely engage in.

Andrew said he had no problem attending counselling but he did not know why others thought he would benefit from it. Referring to his teachers, he stated that the only thing that would be gained by counselling was that others would be pleased because he would be 'out of the way as usual'. Despite his physical stature, Liz noticed that when Andrew said this, he seemed small and diminutive; his posture was hunched and almost foetal like. Liz reflected back to Andrew that he didn't seem pleased by the idea that people wanted him out of the way and asked if his teachers were the only people that seemed to enjoy his absence.

Andrew then gave an outline of his life, explaining that it was only men who wanted him out of the way – male teachers, mum's boyfriends and male peers. Most of Andrew's early years had been deeply fractured; he could report no consistent male role model, just a series of men who drifted in and rather violently out of his family's life. Despite his apparent physical maturity, it was clear that Andrew carried a rather young and naive sense of blame for the patterns in his mother's relationships. 'They get sick of me you see'; 'They don't mind my little sisters'; 'It is only my dad doesn't keep in touch'.

Liz invited Andrew to explore how he felt about 'being out of the way' and he explained that sometimes it was for the better. For many years there had been multiple violent incidents that he had heard and observed. These culminated in his mother being so badly beaten that she had a punctured lung and was unconscious. Andrew was deeply disturbed by this incident, explaining he regularly 'saw' it when he closed his eyes and he 'daydreamed' about it. With the help of supervision Liz began to realise that Andrew was describing early signs of post-traumatic stress and that his daydreaming appeared to be an indicator of intrusive daytime imagery. Liz's supervisor encouraged her to give Andrew more space to explore his daydreams.

Andrew explained daydreaming was why he had been excluded from class. He was being seen as uncooperative and had been described as blatantly ignoring classroom instructions. In fact what Andrew said was happening was that he was 'zoning out' in thinking about what had happened to his mum.

In his own language, prompted by accurate reflections from his therapist, Andrew began to articulate the internal conflict he experienced between physically appearing as an adult while internally feeling young and fearful. 'I'm built like a brick shit house'; 'I should be able to protect my mom. I'm big enough but I'm a pussy'.

Andrew's stature was a real hindrance to him as he was regularly perceived as being an adult. This led others to place unrealistic expectations upon him in terms of his behaviour, attitude and emotional resilience. Andrew had internalised many of these expectations, especially when it came to protecting his mother. His inability to live up to these internalised standards ultimately led Andrew to feel a great sense of shame and physical and emotional impotence. Andrew's arrogance, non-chalance, and burgeoning aggression, seemed to be his way of covering what he felt sure others could see in him.

Liz recognised initially she had also been a little blinded by Andrew's stature and that she had the challenge of building a relationship with a vulnerable young man whose sense of self was incredibly fragile. The work began to focus on what attributes Andrew wanted people to see. Andrew said he wanted people to see his sporting and artistic skill, although he wrestled with the latter as this was 'a wussie's game'. The remainder of Liz and Andrew's work focused on attending to the common question that is present for many adolescent clients (Horne, 1999): 'Who will I be?'

Over the following weeks Liz and Andrew returned to Andrew's image of who he might be and explored which elements of this could be facilitated through change within his life and which elements needed to be accepted as currently unachievable. During one particularly difficult session, Andrew became distressed when he realised that he could never have protected his mum from domestic abuse as for many years he'd been physically unable to because of his youth and small stature. His recent physical development had left him with a feeling that he should have done something to protect his family. This led Andrew to look at the limits and scope of his own personal responsibility. Andrew found this frustrating but was willing to accept on a cognitive level that he had not had the capacity to protect his family and because of this, he could not be responsible. Throughout the counselling encounter Liz used active listening to try and enter Andrew's world and congruently worked with the dissonance between his developmental levels.

## Summary

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In this chapter we have:

- Argued that we need different therapeutic skills and knowledge when working with children and young people
  - Detailed the competencies required and highlighted the importance of the skill of active listening.
  - Considered the impact of the developmental stage of the client on the therapy
  - Explored the differences in working therapeutically with children, young people and adults
  - Provided a case study to demonstrate the dissonance that can occur between different elements of development and how the therapist uses her therapeutic skills to attend to the whole client experience
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## Reflective Questions

- Can you think of a child or young person where their physical, emotional, cognitive or behaviour development is not synchronised? Does this cause issues?
- Are there any special attributes or qualities that you feel a therapist working with children and young people should have? If so, what are they and why?
- Why might it be important to communicate to carers of the child or young person something of what is happening in your therapy sessions?
- What do you think are the most important skills for a therapist when working with children and young people?

### Learning Activities

- Think about your school days and about your teachers. Think of one good teacher and one bad teacher. What were their qualities/behaviours/attributes that made them good teachers? What were their qualities/behaviours/attributes that made them bad teachers? Can you list them? Think about your 'good' list. Does it connect in any way to the suggestions made by Rogers and Farson (1987) about how to listen actively?
- Write a list for yourself of the different skills required to work with children and young people. If you do not already have these skills, where could you learn them? Do a search for training providers.
- West (1996) suggests that in order to work with children and young people we need to 'understand and come to terms with what has happened in [our]/their own childhood, adolescence and adulthood, including child-rearing and parenting issues'. How could you do this?
- West (ibid.) also suggests that we 'work alongside troubled children without being damaged by the children's pain'. What sort of strategies can we put in place for ourselves to help us manage this?

### Further Reading

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### Online Resources

- BACP website: [www.bacp.co.uk/](http://www.bacp.co.uk/), especially the BACP Children and Young People Division and the Competences for Working with Children and Young People.
- Counselling MindEd: <http://counsellingminded.com>, especially Modules CMD 02: Participation and Empowerment; CMD 03: Legal and Professional Issues; CMD 04: Cultural Competence; CMD 05: Initiating Counselling; CMD 07: Relational Skills; CMD 08: Therapeutic Skills; CMD 10: Concluding Counselling.
- Children and Young People's Improving Access to Psychological Therapies (CYP IAPT): [www.cyp-apt.org](http://www.cyp-apt.org).
- Griffiths, G. (2013) *Helpful and Unhelpful Factors in School Based Counselling: Client's Perspective*. Counselling MindEd Scoping Report. Available at: [http://counsellingminded.com/wp-content/uploads/2013/12/griffiths\\_MindEd\\_report.pdf](http://counsellingminded.com/wp-content/uploads/2013/12/griffiths_MindEd_report.pdf).