

Editorial

Alex Millham

I remember meeting a family several years ago and being unable to offer them help with changing their son's violent and aggressive behaviour. I tried all that I knew and perhaps there was little that could be done. My ineffectiveness continued to bother me. It meant, however, that I became interested when I heard of an approach that specifically addressed adolescent-to-parent violence. This was called non-violent resistance therapy. I began to find out all I could about the approach and began using it, with some success.

Research in adolescent-to-parent violence is at an early stage. Amanda Holt's excellent review of the literature highlights many of the issues that are troubling with this area. She begins with the problem of the language. Is it appropriate to call this domestic abuse, especially where the perpetrator is a child, and also likely to be a victim? Despite this, the similarities to adult-to-adult domestic violence can be alarming. The parents can find themselves isolated and doing anything possible to avoid conflict. This can lead to extreme levels of obedience to the child's wishes. In other situations, parents are as aggressive as their child. Non-violent resistance offers a way out of these patterns by focusing on what the parent can do rather than them being responsive to the demands of the child.

Violence is troubling in many respects. Prevalence is hard to measure and has inconsistent responses from services. In a recent situation, I found a referral regarding child-to-parent violence rejected by child social care, as they felt it was an adult-safeguarding issue and adult safeguarding rejected it as they felt it was a child issue. Child-to-parent violence is also difficult for therapists as they may struggle to see a child as a perpetrator of violence. Peter Jakob, Jim Wilson and Mary Newman respond to this here by emphasising a child focus in this work.

As with any approach that purports to be new, there are, as Omer in this issue describes, roots of the approach in earlier approaches. Part of the approach has been a more active therapist role in initiating change. This has meant I have taken older books from my shelves that have perhaps fallen out of favour in family therapy training. These include work by Jay Haley, Sal Minuchin and, a favourite of mine, *The Tactics of Change: Doing Therapy Briefly* (Fisch, R., Weakland, J.H. & Segal, L., 1982, Jossey-Bass).

I hope this issue provides a useful introduction to this approach. It includes contributions from the originators of the approach from Israel, and then has papers that cover the theoretical implications and how it may be applied in different settings. I am pleased this issue has had contributions from across the world and that there is so much enthusiasm for this work in the UK. It would have been easy to fill several issues with the possible contributions and I apologise for work that was pruned or not able to be included. The issue describes several applications of the approach. It has been used in multi-parent



groups, on an adolescent ward and with parents of children with a learning disability.

I have been compiling this issue at the same time as the news is covering the death of Nelson Mandela. A common theme is how he made a choice to meet, not just his prisoners, but also everyone he came into contact with, with humility, understanding and compassion. Far from this being a weak position it became a powerful position that resounded around the world and led to far less violence than might have been predicted in South Africa. His was also not a soft approach but a determined one. There is something of this spirit contained in the approaches in these papers. Practitioners recount how responding with understanding alongside firmness can change seemingly intractable situations.

This issue also includes a moving and inspiring account of how a local primary school managed the effects of the Woolwich attack in which a soldier was brutally killed a few metres away.

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Presence, resistance and attachment – “I am your parent; I will stay your parent”

An interview with Haim Omer by Alex Millham

Alex: How did you come to apply a political approach to the family?

Haim: When I wrote my first book, *Parental Presence: Reclaiming a Leadership Role in Bringing Up Our Children* (Omer, 1999), and the book was already in press, I had two cases of extreme escalation in a child's behaviour. This caused me a lot of problems. I was concerned that the approach on parental presence and parental authority described in the book might lead, in some cases, to a worsening escalation. The central idea of the book was that you can establish parental authority in a positive way by basing it on the message, “I am your parent; I will stay your parent, you can't divorce me, you can't fire me”. This has remained my central idea.

After those two cases, I thought about what I should do? I could not publish the book in that form. So, I withdrew it and wrote an additional, ad hoc chapter on preventing escalation that I was happy with; I had done my duty and could now publish the book.

However, I was dissatisfied because the problem of escalation had not been approached in a conceptual way. So, I looked for a solution; how can you advance authority based on parental presence whilst preventing escalation? That's where I became acquainted with the philosophy of non-violent resistance, as practised by Ghandi and Martin Luther King. This was extremely relevant for me because non-violent resistance is the only political resistance in which the struggle is conducted by and through presence. You don't throw things at your opponent, you don't try to hurt them; you make yourself present as the way to resist and fight. Moreover, non-violent resistance is the only form of struggle in which the question, not only of violence but also of escalation, is given absolute consideration from the first moment. It is not only that you make yourself present in a very

assertive and decisive manner but also you do it without attacking your adversary and without doing things that might lead to escalation. In non-violent resistance, I had a method in which presence and the prevention of escalation were two sides of the same coin. That was exactly what I needed; so I became acquainted with the principles, the strategies, and the tactics to see if I could translate them into the family context. That is how my book, *Nonviolent Resistance: A New Approach to Violent and Self-Destructive Children* (Omer, 2004), came about: seeking the solution to the quandary, how can I integrate the concepts of presence and preventing escalation at a basic conceptual level – that's how it came about.

Alex: Do you see your approach as also coming from family therapy?

Haim: Yes, of course. Various family therapists influenced me and Salvador Minuchin was the primary influence in the development of my approach. He was the first to make clear the importance of boundaries: boundaries between parental and children's subsystems. The idea that boundaries can be too permeable or too detached was a very attractive idea for me in formulating the principles of parental presence. The parents are present to the child in ways that are permeable, that means they allow the child and encourage the child to get near to them. The idea of a boundary is very important in how the parents present themselves to the child. In addition, aspects of his approach were akin to my approach. Unlike some of the well-known family therapists that came along later, Minuchin was not afraid to tell parents what he thought. Afterwards, this approach was named ‘directive’; this simply means he was not afraid of making his principles clear. He didn't imagine he was only allowing the parents to make their own ideas evident. He was clear that the therapist is present with the parents

just as much as he thinks the parents could and should be with the children. The therapist is a person with clear ideas within the therapy, which he expresses to the parents.

Of course, the whole systemic analysis of child behaviour is vital. For example, with Eli Lebowitz, I have written a book, *Treating Childhood and Adolescent Anxiety*, for the parents of anxious children (Lebowitz & Omer, 2013). Our analysis of anxiety in children is a systemic analysis. The child cannot be understood or treated separate to the parents. It is always a systemic, continuous interactional process.

In all aspects, non-violent-resistance therapy is a clear systemic family approach. All of the important articles and research I have published were published in journals of family therapy.

Alex: How might you say your approach is unique or different from other family therapy approaches?

Haim: First, the setting. We work with parents and see them as the clients. We don't see the whole family, together. We often make home visits. This is done by a team member, not the therapist who sees the family at the clinic. We believe that, in working with the parents, we can have a clear focus for the work. Whilst helping them become more effective, we also consider the needs of the child; but, our direct clients are the parents. When we measure the effectiveness of the approach, we first go through the parents; we use scales and questionnaires in which, for instance, the parents assess the child's symptoms. Only later do we use more direct ways of measuring effectiveness. This is a major aspect of our approach. In that sense, perhaps, we are the most parent-friendly approach there is: we not only attribute central importance to the child's suffering and needs, but also to the suffering and needs of the parents.

Actually, we believe the suffering and needs of both can be improved together or not at all.

When we work with teachers, they are our clients. Our purpose is to strengthen them as teachers in a positive but not an authoritarian way. We endeavour to make them feel more supported, more protected, in order to help them to have better ways of reacting at their disposal.

All of these are ways of centring on the adult who is the caretaker of the child; so I would say this is a caretaker approach. For example, there is a project on non-violent resistance in Flanders in Belgium in which the approach has been adapted to foster parenting. You wouldn't be able to do this if you didn't have this emphasis on the caretaker. That is the major difference between us and other family approaches.

Alex: When I have met non-violent-resistance practitioners in the UK, they all seem to emphasise something slightly different in their work. For me, it is pattern interruption; for one of my colleagues, it is always thinking about the young person's unmet needs. What is the key element for you?

Haim: Out of the many, many people practising the approach in many countries over almost 16 years, there is a whole gamut of differences. I would say that, sometimes, the softer elements of parental presence have had a greater emphasis than those that signify actual resistance to violence and self-risk behaviours. For me, the approach does not only express non-violence but also resistance. When you deal with violence, you cannot only be non-violent, you have to be non-violent and resist at the same time. The main emphasis for me is never to forget you are also resisting: you are resisting violence, you are resisting abuse, you are resisting humiliation, you are resisting self-risk activities, and you are resisting self-destruction. That is also the main difference between our approach and the approach of non-violent communication, which stresses only non-violence. We stress both together, non-violence and resistance; this is the key element.

That is why I never give up on such elements as giving the parents sufficient support (from relatives and friends), which helps them resist better, but also escalate less, because they feel less cornered and more transparent. Involving support groups makes the parental

approach more non-violent and more resistant at once. I can never give up on central measures such as the sit-in or the telephone round, in which parents look in a spirit of resistance for a child who has disappeared – “*We are not going to put up with your disappearing and staying nights away from home*”, or “*We are not going to put up with your self-destructive behaviours, we are going to resist them*”. So, that is the emphasis that makes my approach distinct from what some people do. Breaking established patterns or reconciliation moves in looking for the unmet needs of the child are important elements of the approach, but I wouldn't say they make the approach unique. What makes the approach unique is the integration of those elements and resistance. That's why the approach is more than psycho-education. We are mobilising the parents to stand up tenaciously and, with support, against violent and self-destructive behaviours.

Alex: Can you say something about recent developments?

Haim: We have a large gamut of interventions with a variety of problems. We began with children and adolescents with externalising disorders. The programme was developed and initial research done with children with ADHD, with conduct disorder, and oppositional defiant disorder. We published articles and studies on this. Then, we began developing in other directions. We looked at what is common between anxiety disorders and externalising disorders. We understood that, in both, we are helping parents perform an anchoring function for the child. Strengthening them, so they are no longer free-floating agents, helps them take a clear position and, through this, help the child stabilise him or herself. With anxious children, we have research showing that, when parents are able to better anchor themselves, children become more able to stabilise against the pull of their anxiety.

An extension of the model is for the parents of young adults who continue to be extremely dependent on and demanding of their parents. We call this ‘entitled dependence’. They make demands; they don't function, they don't study, they don't work and, very often, they stay at home and reduce contact with the external world. We have published a study of 27 such families in *Family Process* (Lebowitz *et al.*, 2012). With this work, we are

touching on problems that are becoming very widespread in modern societies – the problem of young people who are now not so young but continue to show absolute dependency and continue expecting, demanding and receiving services which is not good for anybody – not for the parents and not for them.

We are also in the process of writing a special protocol for helping parents deal with suicide threats by adolescents and young adults. How can you resist suicide threats whilst giving support? This is a special challenge, which has not been stressed in the literature. The threat is clearly interactive. Otherwise the person would not threaten and would simply kill him or herself. The moment the person threatens, there is someone else involved; it is already an interaction. The parents, or significant others, become involved and will influence outcome. Thinking about this in strictly individual terms, by trying to diagnose the individual in depth, for instance, disregards the patently interactional aspect of the threat. That's one of the lines we are working on intensively at present.

We have also extended our model to institutional settings, working in hospitals both for children and young, or not so young, adults. Using the same model developed with entitled dependence, we have worked with staff and the family together. We have also developed protocols for helping parents in the normative range with common problems like computer misuse. We called the parental attitude we are furthering, ‘vigilant care’. This was first described in the book, *The New Authority* (Omer, 2011). This is a sensitive but decided kind of parental presence. We have developed protocols for increasing parental involvement in areas like alcohol use, drug abuse, cigarettes and problematic sexual exposure. We have a special intervention for parents of young drivers, showing that parental involvement significantly reduces risky driving in someone who has just received a driving licence. This is usually with males, as most females seem not to need it. There are very clear research findings that young male drivers are dangerous. We are also working intensively with the parents of diabetic children; using a protocol for treatment, which is also relevant for other chronic diseases.

Theoretically, I would say the most important recent development is the integration of our model of authority with attachment theory through the concept of the anchoring function. We have recently published a paper about this in *Family Process* (Omer *et al.*, 2013). At present, the anchoring function of parenting is the most significant concept in non-violent resistance.

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Haim Omer, from the School of Psychological Sciences, Tel-Aviv University, is the founder of non-violent resistance in therapeutic and educational contexts. Originally developed for the parents of children with externalising disorders, it has been extended to many other conditions (e.g., anxiety problems, parents of aggressive and dependent adults, parents of children with chronic illnesses, foster parents, psychiatric hospitals, computer misuse, teen driving, Asperger syndrome, school refusal, prevention of alcohol and drugs, and more).

The ‘sit-in’ – A demonstration

An interview with Uri Weinblatt by Alex Millham

Alex: What is a ‘sit-in’ and in what contexts have these been used before?

Uri: The ‘sit-in’ is one of the fundamental interventions in the non-violent resistance programme and considered by many the most powerful. It consists of the parents entering and sitting in the child’s room (when the child is there) while remaining relatively quiet. The sit-in is an intervention aimed at providing a new experience for the parents and child when in conflict. It is a demonstration of parental presence, parental determination and parental caring, using the principles of non-violent resistance to shift the power balance within the family. What are these principles? First, the planned use of time. The sit-in takes time, usually around 45 minutes, although, in certain situations, it can also be used for shorter periods.

We know children are good at using time to get the upper hand in family conflicts. From an early age, they learn that, if they are persistent enough, there is a good chance their parents will give in. Through the sit-in, we help parents use time in a way that helps them feel the longer the conflict drags on, the better chance there is for it to end up in a way that will move the family forward. This is one of the fundamentals of non-violent resistance – don’t expect immediate results, but have a strategy that uses time, patience and determination to impact the other.

The second principle uses proximity to the child as a key element leading to change. During a sit-in, the parents remain with the child in his or her room. They do not leave the child alone (as is required during a ‘time-out’ intervention). Instead, they use their physical presence as an additional dimension in the demonstration of parental presence. The third principle is quietness, which focuses on parents monitoring and regulating the amount of talk from their side. By remaining quiet and even completely silent throughout the intervention, the parents minimise escalations that are a result of provocative interventions such as lecturing, blaming and criticising.

Each one of these principles – time, closeness (or proximity) and quietness – communicates a specific message to the child: time communicates commitment; closeness (or proximity) sends a message of connection; quietness communicates control or, more accurately, self-control.

Alex: Could you describe what it looks like and give an example?

Uri: The parents enter the room for a period of 45 minutes (in the basic manual – an hour). After they have entered, they sit on the floor, often next to the child’s door. They announce they are not willing to accept certain behaviours and that they will sit there until the child comes up with some kind of solution to the problem. Then the hard part begins: the parents need to sit quietly for the whole time and contain and manage the child’s different reactions.

Alex: What are the sorts of problems this is typically used with?

Uri: Originally, we developed it as a means for dealing with aggression and violence, but it is also used in situations of disconnection, avoidance or self-destructive behaviours. I often use it in circumstances of avoidance – when the child does not go to school (school refusal), when they are avoiding social activity, are not willing to leave home or are disconnected from family members. It is very useful in many non-cooperative situations.

My experience has shown me that the specific problem that led the parents to intervene is not the main factor that determines how the sit-in will unfold. It seems that, whatever the original problem was, both parents and child typically go through certain emotional phases that ultimately lead the parents to feel empowered and the child to feel, in some way, that they actually have more freedom in their relationship with their parents.

Alex: Why would they feel more freedom?

Uri: Of course, children do not like this intervention. Initially, they feel ganged-up on, controlled and pressured. Some of their power is taken away from them,

ation of parental presence

which can be experienced as painful and a loss. However, in the period after the sit-in, we can often observe the child's range of behaviours and emotions increasing, becoming richer and more nuanced. Children develop more freedom in the relationship with their parents in the sense that they can relate in ways they didn't before. They can experience being with their parents without the usual fights, power struggles and explosions. When a sit-in is successful, children not only refrain from being aggressive, but feel aggression isn't the way to solve problems. They try relating and interacting in ways that suggest they are not acting out of fear, but are allowing themselves to act pro-socially without feeling weak or humiliated. Sit-ins create more options for the child and the parent in dealing with situations of conflict. Yet, children are not the only ones that experience a sense of freedom. Parents learn they can emancipate themselves from their patterned reactions to the child's unruly behaviours. While in their daily lives the parents fluctuate between explosive, rigid reactions and permissive, giving-in responses, the sit-in provides an experience of doing something different that is neither attacking or giving up.

Part of the parents' freedom comes also from the goal of the sit-in. Although they tell the child they will sit in his room until he or she finds a solution, the criterion for success is not whether there is a solution or not. Actually, many children change their behaviour without ever giving a solution. Success comes from the parents' ability to sit with the child. It is their presence and this different type of togetherness that leads to change.

Alex: One thing people have said when I have described the idea when teaching is, "Doesn't this result in shame for the child?" I'm guessing this is a question you have had many times. What is your response?

Uri: Yes, initially the child might experience shame. However, the time factor and the sensitive parental reactions allow the child to confront shame and ultimately improve in regulating it. At the

start of the sit-in, the child can experience shame for many reasons – the parents are focusing on a behaviour he or she is ashamed of; he or she can feel blamed, can feel like a victim, can feel a diminished sense of power. Moreover, children who act out don't like to face their problems. They hide from them, act out, avoid, deny, do everything except dealing honestly with their weakness. The sit-in leads to dealing with, and facing, their problem instead of hiding, avoiding or blaming others.

It is important to note that the child is not the only one who experiences shame. The parents also feel shame during different parts of the sit-in. For example, the child can become belligerent towards them, say hurtful things, try to humiliate and belittle them. All these behaviours are exactly the ones that, in their daily lives, lead parents to feel disrespected, unappreciated and insignificant. In the sit-in, the parents are coached on how to regulate their own shame about the child's shame.

During the intervention, parents and child experience a range of emotions – anxiety, anger, sadness and helplessness. Time allows different emotional reactions to unfold and facilitates their management and regulation. For example, the initial response for many parents is fear and, as time passes, it transforms into other emotional states. At the onset, the child usually experiences anger, which transforms into other, more positive emotional states.

Alex: Could you give me an example of a sit-in?

Uri: Last week, I heard of an interesting sit-in implemented by parents I had been

counselling for the previous two months. They entered therapy because of their 16-year-old son, who was in trouble at school, abused drugs and hung out with the 'wrong crowd'. He wasn't aggressive towards his parents but disconnected, and he was about to be expelled from school. He refused to do any academic work and would stay out at night. The parents entered their child's room

and announced they were going to do everything they could to help him successfully finish high school and oppose his disappearances and his nightly activity. Initially, he was shocked by the fact they entered his room. The mother was crying at the beginning of the sit-in and it was the father who was leading it. As time passed, she regained her composure and related to her son. He initially didn't

understand why they were there; he thought it was ridiculous. He threatened to leave the room. He threatened to jump out of the window and his parents moved close to the window. After threatening, he shifted into ignoring his parents and, later, started suggesting solutions that weren't very helpful. Yet, by the end of the sit-in, he was talking very differently to his parents. We usually prepare parents not to expect positive constructive-communication during a sit-in. However, this sit-in actually ended with a constructive conversation between the mother and son. He admitted not believing in his ability to be successful in school and did not rebel when the parents said they would do everything in their power to help him believe in himself. This took place on a Thursday. The parents reported that, by the weekend, their son

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was much more present and connected with them.

I believe the positive reaction was a result of it being part of a comprehensive therapeutic-process, based on principles of non-violent resistance: the parents showed up in places the child was hanging out, continually de-escalated dangerous interactions and unilaterally acted kindly and warmly towards him. The sit-in was one intervention in the whole therapeutic process. It was another manifestation of an attitude change. By itself, it would probably not have changed things so quickly.

Alex: How would you normally judge a sit-in to be successful? I am guessing, from what you said, it's about different ways of relating, rather than an immediate solution.

Uri: Immediate change is, of course, always welcomed. For parents who felt helpless and afraid of their child, seeing change in the child's behaviour is quite a dramatic experience. It cultivates hope, re-motivates them and lets them experience themselves having influence. I always wish parents to have such an experience. But, immediate change in the child's behaviour is not the only criterion for success and not even the main criterion. Many of the families have been dealing with behavioural issues for years. There is no one intervention that can make all that go away. An expectation of immediate change can lead both parents and therapist to experience disappointment and despair. At the same time, the sit-in can always lead to parents experiencing themselves, their reactions and the child's reactions, differently. In this sense, it can be used as a laboratory, a unique space where parents can practice de-escalation behaviours, self-control and relating differently. They can exercise how not to get engaged in destructive fights, how to remain calm in the face of adversity, how to maintain self-control, how not to provoke and blame the child.

When parents change their own provocative, passive and, in general, ineffective behaviour towards the child, major changes are likely to occur. So, a good sit-in is one in which both the child and the parents change their behaviour.

We evaluate these changes in the days after the sit-in. With parents who were afraid of their child, I check whether the sit-in made them feel less afraid. With parents who are angry with their child, I evaluate whether they developed more empathy; and with parents who are anxious, I wonder whether they have become more self-assured and less guilty. **Alex: Earlier, you talked about the time factor. I was wondering whether you do shorter sit-ins at different times?**

Uri: The sit-in was developed as an intervention in which parents sit with the child for an hour. Yet, with different families I can suggest shorter periods, for many different reasons. I evaluate the parents' level of motivation and determination. If I think an hour will be more than they can handle, I suggest shorter periods. I want them to feel successful and so tailor interventions to suit their abilities. This is also the reason we coach teachers and school staff to preform shorter sit-ins; usually no more than fifteen minutes, which still remain very helpful. The idea is to work collaboratively and not get stuck in our own formulations. The parents also judge whether it was effective or not. For example, some parents evaluate real change after 20 minutes and choose to leave the room at that time. They feel there was some shift within the child and some shift within themselves. I find this perfectly acceptable and am happy when it occurs. For some parents (and to be honest also for some therapists), the original sit-in seems like an intervention that is too dramatic, too extreme, too scary, and I do not want them to give up the idea because they think it is beyond their ability. While time is an important factor, we do not want to remain rigid, forcing the parents to stay for a period that might cause them not to use this tool.

Over the years, I have devised different types of sit-ins for different purposes and populations, which added variations to the original intervention. For example, let's take the question of where the parents should sit. Originally, parents would sit next to the door and remain there throughout the intervention. Now, I coach parents to be more flexible with location and level of distance from the

child. My revisions were all inspired by actual successful sit-ins, improvised and elaborated by real parents. I like listening to these improvisations, I try to learn from them and replicate them with other families.

At this time, another major effort on my part is to use the sit-in as an opportunity to improve the parents' (or couple's) ability to work together as a team. Therefore, in addition to coaching the parents on how to relate to the child, I also coach them on how to relate to each other. I emphasise how to use their individual differences to move the intervention forward; how to comfort each other and support each other. In the example mentioned earlier, the mother was initially crying and somewhat paralysed. Her husband took the lead and dealt with the threats the child threw in their direction. Yet, once the child became more collaborative, the mother took over and led the conversation with the child. These parents worked together very impressively. The experience of sitting-in not only contributed to moving their relationship with their child forward, it also strengthened and enriched their own relationship as a couple.



Uri Weinblatt is a clinical psychologist and heads the 'systemic mirroring' family therapy institute in Israel. During his doctorate studies he wrote with Haim Omer the non-violent resistance manual for parents and led the first out-come study. He has been practising the approach for over ten years and has contributed book chapters and articles on the subject.

Love bombs as acts of resistance: *Reflections on non-violent practice*

An interview with Rachael Aylmer by Alex Millham

Alex: You have been using this approach extensively with groups and individually to address adolescent-to-parent violence. What has non-violent resistance added to your practice?

Rachael: Clarity. I would say clarity is the first thing. I could understand the approach both as a parent and as a parenting-support worker. It was formatted in a way that my brain could grasp and follow. It helped me to manage conflict because, no matter what happens, wherever I go, whoever's house I visit, I find myself seeing the same repeating patterns of parenting.

One pattern is where the parent is saying too much. The parent is parenting but not necessarily effectively. They might be trying desperately hard to address difficulties but, actually, they are not seeing clarity in their parenting; not understanding there is effective parenting and non-effective parenting.

There are also lifestyle patterns. So you think about two people who enter a relationship, which can end up with one of them raising a child. There is often an absent parent impacting on the child's development and emotional wellbeing. The present parent is in conflict with the other parent. This can lead to resentment, which can then impact upon the child's behaviour.

Alex: So there are patterns of parents saying too much, patterns of lifestyle and parents not being present at all?

Rachael: In the seven years I have been using the approach, there has almost always been absenteeism in the child's upbringing. A parent could be absent through mental health, through depression, through illness, through hospitalisation, through imprisonment. So, the absence in that child's upbringing and development has an impact. Conversely, where parents are more grounded and there is less absenteeism, such that the parent is more present, aggressive behaviours are less.

Alex: When a child is violent, I guess it makes it hard for the parent to be present in that child's life, as well.

Rachael: Yes, but I don't think the parents see that; I don't think they make that connection. Parents don't see the violence as existing in a context; they just see this angry child.

Alex: So, it has given you the clarity, in terms of understanding some sort of framework; clarity in seeing patterns in families and clarity about making some sort of connection about what sort of things contribute to violence. Lots of parenting approaches give a structure; what do you think is different about the non-violent resistance structure?

Rachael: I've done training in the other sort of approaches and they are effective and they work; I think the thing I liked most about non-violent resistance is it focuses on the parent and caregiver. It is around the emotions for the parents; it is about what parents can control. This leads to looking at what is both within and outside of a parent's control and looks toward understanding how ineffective it can often be to try to control a child's behaviour. As the child becomes older and possibly less communicative, the approach's focus on parents becomes increasingly useful. When I think about my practice with parents, I don't necessarily ever meet the child. My intervention doesn't have to be with the child.

Alex: Because you are looking at the parent's response to the child?

Rachael: Yes, so as long as there is an honest beginning where the parent can openly share aspects of their behaviour, for example, how they hit their child, the whole process is around the role of the parent or caregiver.

Alex: What other things do you think are different?

Rachael: Well, I think the other approaches focus on drawing up contracts and the use of rewards. This can wear parents down. This approach gives them some kind of

respite from that. There is no contract to be drawn up, so the direct work is done with the parents. It is through the parents empowering themselves to make more positive choices and raising their parental presence in contrast to the absence I described earlier.

Alex: Could you give me an example of that; one with a parent that managed to do something different through raising presence and that wasn't about rewards and consequence?

Rachael: One parent I'm working with now is in conflict with her son but has decided to use reconciliation for all three of her children by leaving positive notes for them. She is very, very eager to build bridges. She recognises there is a gap and that there has been an absenteeism, and she is very keen to build that relationship back, so she uses reconciliation gestures quite often.

Alex: What do these notes look like?

Rachael: The children are quite young and she quite often puts a little note in the boy's lunch box. Last week, when it was his first day back at school, there was a sincere, "Have a great day, you're my star, big boy. Mum x". What she has found, and what we have been monitoring, is that the impact of these notes is quite significant. It says a lot about her that she has adopted the mindset to do this because, sometimes, you can offer it to parents and they don't necessarily see the relevance or feel able to be proactive enough to use it. She is remembering to do it and is using it at times where she feels it's necessary. It's softening his approach towards his mother. He is starting to open up towards her about his feelings and to share his thoughts, his good days, his bad days. These are things he never did prior to her using different strategies.

Alex: How does it make a difference to her to do that?

Rachael: She feels closer to him and therefore there is a stronger bond. She feels more empowered, more in control (I use that term loosely). She feels she is more in control of

herself and more in control of her emotions. She feels she is parenting him wholly now.

Alex: *And part of that is due to these gestures?*

Rachael: We worked on other strategies like de-escalating conflict and we have done some 'love bombing' stuff.

Alex: *What's that?*

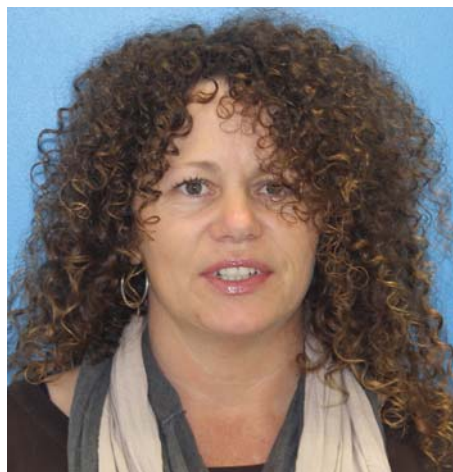
Rachael: It is like reconciliation gestures but in a much more intense way. So we have got her to take him out for a whole day, just the two of them and had child-care sorted out for the other children. She spent the whole day telling him how much she loved him. They went bowling. She told him how much she loved him and they went swimming and she spent time with him and said, "You are so lovely".

Alex: *Most of your work now is with younger children and non-violent resistance is typically working with teenagers who are aggressive towards their parents. How have you adapted your approach to work with younger children, how has it proved useful so far?*

Rachael: I am using more reconciliation gestures and am considering raising parental presence. I look at this in detail. So, if you look at a sort of circle, a time frame, 1 to 24 hours, and break down how many hours are spent by the parent doing exactly what, it can be telling. For one parent last week, we identified that she has this time-consuming routine; her children's basic needs are met, there is washing, ironing, clothing, feeding, but she spends no time with her kids.

Alex: *Do you find the opposite sometimes?*

Rachael: Yes, the whole point of that exercise is to get parents to recognise their parental presence. We use it on a floor plan. Where do they sit in the house, and consider where is their presence mostly identified by the child?



Rachael Aylmer works for Families Moving Forward in Portsmouth.

"We couldn't give up on study – many voices

Michelle Shapiro and the family members

I was a seasoned child and adolescent mental health practitioner when our service received the referral for Michael, a 14-year-old boy, who was almost constantly angry, volatile and violent at home. This aggression was expressed verbally, but equally through physical outbursts and violence to 'things' and to his family. He was quiet and not a problem at school. At the time of this referral, many of the clinicians in our service had undertaken training with Haim Omer, the originator of the non-violent-resistance programme. An initial telephone contact was made with Michael's parents, who informed me he was not likely to engage. They were worried that, as a result, their family would waste our time. Because of our recent training, I reassured them, with greater confidence than I might have previously, that we could work with them directly, even if Michael never engaged with us.

What follows is initially a synopsis of my involvement with Michael and his parents from my perspective, followed by a synopsis of the family's perspective of their involvement with us. We will also recount in some detail the aspects of the work undertaken which seems to have allowed this once desperate family to function predominantly well and with joy.

An outline of the contact with the family from the onset to an ending

Assessment

As predicted, Michael did not engage well in the initial assessment and refused to attend further sessions. His main communication was that he did not feel he had a problem; the problem was with his parents. Fundamentally, he was satisfied with the situation at home. He liked being angry and in control. Thus began the non-violent resistance journey for his parents, initially with only me and, subsequently, by also joining a multi-parent or carer, ten-week-long programme being offered by a joint-service initiative within our trust.

During this period, several complementary therapeutic interventions were offered, and accepted, as well as a realisation of the probability of a neuro-developmental disorder being co-morbid (or causal) to the aggressive and hostile behaviour at home.

Work with parents and school

Based on the presentation of an out-of-control and violent child, not willing to engage with services, coupled with fundamentally loving and committed parents who felt hopeless and powerless, it was evident early on that non-violent resistance would be a valuable approach. We began single-family work along with supportive work, including a consultation with his school. We considered and adopted most of the principles of the approach including de-escalation and prioritising the behaviour to be addressed. It was a relief for both parents to have permission to overlook a great deal of the socially unacceptable behaviour and to address his violent behaviour as the first priority.

Multi-parent group work

We agreed they would join me in the next multi-parent, ten-week training program offered by a team of clinicians in our service. They were fearful and had a sense of shame in joining the group – but they were also desperate for change and progress.

Active listening

Gains from the parent group were supplemented in our continuing individual family work with such strategies as active listening. This highlights that communication can be part of the problem. 'What is said' and 'what is heard' are often very different – and need to be 'checked-out'. By correctly and fully hearing the feelings of another, those feelings are able to shift and change, sometimes for the first time. It transpired that Michael did indeed have real difficulties with understanding and communicating. He responded well to this careful communication style.

our son": *One non-violent resistance case*

Trauma-oriented work

I have also trained and specialised in trauma-oriented work, and this informed my formulating that unresolved parenting-oriented trauma was making it very difficult for them particularly to persist with de-escalation. We had several sessions specifically around trauma, initially using eye-movement desensitisation and reprocessing and then an alternative depth-trauma therapy (advanced integrative therapy), which I have come to prefer. The parent-oriented trauma included a very difficult birth experience, as well as the traumatic experiences of having a well-built 14-year-old being violent towards them, his siblings and their property.

Progress

Six months later, the situation at home was sufficiently settled for his parents to encourage Michael to undergo an assessment for psychotropic medication to assist him with his high levels of anxiety. The anxiety led to obsessive-compulsive behaviours, which kept the whole family awake at night. He attended the appointment and thereafter took the medication regularly.

The process of improvement and recovery was initially slow but steady, and has now spanned three years. Michael has completed a year of college. He has learned the world looks different to others than it does to him. In learning to understand and negotiate these differences and challenges, he has begun to regulate his feelings with surprising efficiency. He is now certain his parents love him and are unquestionably 'on his side'. He enjoys being with his family, individually or collectively and, despite him still being challenging, they enjoy being with him.

Most of the improvements have been maintained through the family implementing non-violent resistance in their daily life. They use the techniques with a confidence and certainty and this sense of agency has made a significant difference to their lived experience.



The voices of his parents and sibling: Parents' perspective – father

Before Child and Adolescent Mental Health

Our son, Michael, had always seemed a little difficult. We put this down to his gender, having had a daughter first.

From the age of ten, some aggression was being shown and, by fourteen, Michael was regularly attacking the house, his mother, his sister and me. We had all become afraid of him. He had fractured one of my fingers, into the joint, by bending it back until it snapped. At that time, I used to restrain Michael when he was violent, which put him into an even deeper rage.

We knew Michael had problems. He had been diagnosed with dyslexia and would wash his hands repeatedly until as late as

2am, banging doors as he went. Often, he would burst into our room in the early hours, put the light on and throw things at us. He refused any sort of help. We tried everything we could think of to change his behaviour without success.

We came to child and adolescent mental health exhausted, frightened and ashamed. We were both healthcare professionals and felt we had failed as parents.

The process

He needs fixing, not us

I remember my first telephone call from Michael's therapist, when I expressed doubts he would engage with therapy and she assured me she could work with us to change his behaviour. I am ashamed to say I was very sceptical – he needed fixing, not us. I was totally wrong. Through

"We couldn't give up on our son": One non-violent resistance case study – many voices

non-violent resistance, we learnt about explosive children and how to predict and prevent the causes of explosions. We learnt how Michael saw the world and how difficult things were for him.

Learning to ‘zip it’

Part of this was to stop restraining Michael when he was violent. This was very hard for a man to do and resulted in me receiving some severe beatings (he is big and powerful). I call this my Gandhi moment ¹.

It was very hard to do, but was a step forward in de-escalating the situation. Michael noticed the lack of response and found it harder to hit someone who refused to ‘fight back’. Michael would often shout at me to ‘shut up’. In this situation, I learnt to do just that, to ‘zip it’, so he could calm down. This was alien to the way I had been brought up, but I feel a sense of pride that I can do it – most of the time.

We received invaluable support from Michael’s therapist. I do not think we could have continued without this. I was sceptical about trauma therapy but it gave me the strength to carry on. On one occasion, I could not keep the tears at bay, as I viewed a future where my son and I would not have a relationship that allowed us to go for a beer and a chat together.

Slowly, the techniques we had learnt started to improve Michael’s behaviour. The techniques were reinforced by attending a group, which made us realise we were not alone.

After eleven months, the violence had almost stopped. The use of non-violent resistance enabled us to persuade Michael to see a psychiatrist. Melatonin and Sertraline took us a stage further as did some anxiety management.

We have continued to use the approach on a daily basis.

The situation now

Incredible!

Michael still has challenging behaviour, but violence is a thing of the past. We have completely rebuilt our relationship using this approach. Michael asks for my opinion now and seems happy.

He has a small motorcycle and, soon after getting it, he went for a ride with me into the Kent countryside. We were able to stop off at a pub for a ploughman’s lunch, a drink and an autistic chat about motorcycling! This had previously seemed impossible.

Parent’s perspective – mother Before Child and Adolescent Mental Health

Shame and fear

I read my husband’s account of past events and I still find the facts painful to recall. Three years ago, I was living a ‘roller coaster’ of feelings: helplessness, shame, guilt, fear and exhaustion. I felt our family was falling apart and it seemed beyond my abilities to reverse the process. My shame as a ‘failed parent’ was so immense that I hadn’t shared our difficulties with family members or friends. I was frightened of our son, and frightened for him. His violence and aggression were intimidating in the home, but there was also the fear this behaviour might start to manifest outside of the home, too. Where would this unacceptable behaviour lead him in the future? This worry was constantly on my mind.

At this time, the volatile, unpredictable and tense atmosphere in the home considerably traumatised our daughter. She became withdrawn and reclusive, shutting herself away in her bedroom when our son came home from school.

On reflection, I am ashamed to say that I didn’t understand our son and couldn’t see beyond his disruptive behaviour. I was so numbed by the situation that I was unable to sense his distress and frustration. I felt inadequate as a mother – all my attempts to offer love, support and guidance seemed to be rejected. We had brought both our children up the same way – why had things gone so wrong with our son?

One of my sisters commented that, when she had visited our house, during this difficult period, it had felt like a “war zone”.

The process to rebuild our family

Relief and learning to keep quiet

When child and adolescent mental health accepted our son, I felt a sense of relief that he would now get help. Initially, we were introduced to non-violent resistance on a ‘one-to-one’ basis and the process to rebuild our family began. I found it distressing that he would not engage with our therapist. I did not believe my husband and I could change our home situation without our son’s attendance.

Over the first few weeks, our progress was slow but I learnt to de-escalate

– to keep quiet and not ‘nag’! Prioritising difficult behaviours made the situation feel more manageable. Reconciliation gestures allowed us to continue to show our love for our son. Perversely, it was comforting to perform a loving act even if it received a hostile response. The unconditional love a parent feels for their child kept us focused – we couldn’t give up on our son.

At this time, we were also taught the ‘communication model’. In the slowly developing calm at home we were now hearing and listening to each other. Our son has adopted this technique himself and has been known to remind us, “Mum, Dad – communication model”, when he feels unheard.

‘Breaking the silence’ with supporters

The introduction of ‘supporters’ was a huge hurdle for me to ‘break the silence’ and share the details of our family breakdown with others. I reluctantly agreed to join a parent-group programme. Extraordinarily, my fear became my strength as the weeks progressed. I was humbled by the stories from other families and no longer felt alone. I began to believe we could improve our family life and that I did have the strength to gradually resist our son’s self-destructive behaviour. I felt ready to try an ‘announcement’ and even do a ‘sit in’! I had totally misjudged the value of a group programme – the empathy, encouragement and support that it can provide. We have met so many lovely parents and committed professionals, whilst facilitating subsequent programmes; many have become not only work colleagues but also friends.

Our family life now

United.

I now feel we are a united family; loving, caring and respecting each other’s individuality. I have had my eyes opened to see life through our son’s eyes and to understand him so much better. I have huge admiration for his ability to come to terms with his disabilities and to develop coping strategies.

I feel like a mother again. Our son comes home and shares the events of his day; he even expresses his feelings and discusses his daily challenges. Most importantly, he seems so much happier and more contented. I now believe he can see how much we all love him and, in his own way, he shows us signs of affection too.

We continue to practise the approach since it has become a way of life. The 'non-violent voice' is always in my head and this gives me time to pause and manage the inevitable daily challenges. Our daughter has embraced the principles and works with us to maintain calm. She is no longer fearful and enjoys a good relationship with her brother.

Using support

Our journey has not been smooth and I find it incredible to reflect that I have made the transition from 'fearing the sound of our son's key in the front door after school' to 'looking forward to seeing him come home after a day at college'. This outcome has only been possible with the immense support of my husband and our daughter; our wonderful neighbours, 'supporters'; totally committed therapists and many lovely parents from the group.

Remarkably, an additional 'good' has evolved from this whole experience. We now have the rewarding opportunity to support other families taking part in the programme – helping them rebuild family relationships and bring harmony into their homes.

Sue (20) – sibling

Life at home had become really difficult. My brother, Michael (now 17), was becoming increasingly aggressive and we couldn't see a way forward. I remember feeling scared at home and close to tears most of the time. My family seemed to be falling apart and it seemed to be all Michael's fault. I often wished for him to be taken away and frequently asked why I couldn't have a "normal brother".

"Failed parents club"

In October 2010, Mum and Dad told me they would be completing the non-violent resistance course. Dad called it "failed parents club!" I couldn't see how it might help in any way as I thought Michael was 'the problem' and it was him who needed help. I later came to realise that the approach is not for 'failed parents' and I am proud of my parents for being brave enough to share our family problems and seek support.

At first, the only changes I could see were Michael getting his own way. He was even being rewarded with a chocolate bar after being particularly difficult. My immediate reaction as a sibling was "Where's mine?"

– it just didn't seem fair. In fact, I often escalated situations by deliberately saying things that would cause Michael to react in an unfavourable way. Also, when Mum and Dad tried to talk to Michael on his own and asked me to leave the room, I refused. I wanted to know exactly why I had to suddenly leave the room when I had done nothing wrong. This prevented them from moving forward using what they had learnt from the course.

Understanding Michael, understanding the approach

I was offered the opportunity to speak with a psychologist. I refused because I felt there was nothing wrong with me. I knew what CAMHS stood for and I was adamant I did not have mental health problems. Eventually, I did agree to a session. I am so glad I went because the basic principles of the approach were explained to me. I then understood what Mum and Dad were trying to achieve. I could start to see things from Michael's point of view and realised that often his violent outbreaks were as a result of the frustration he felt. I began to feel sorry for him. I could see that everyday life for him was a struggle and he was taking it out on those he loved.

I agreed to a further five sessions with the psychologist, giving me a chance to talk about how Michael's behaviour was affecting me. It was a relief to get my feelings out in the open. We discovered Michael's behaviour had had a huge impact on my life, even when I was little. This helped me to put some of the more unpleasant times behind me and concentrate on helping create a better future for all of us.

Helping – noticing triggers and keeping quiet

I began to notice what often triggered Michael to become violent, so could try to avoid it. I could even spot when he was getting angry and would help Mum and Dad calm the situation. I had to learn to keep quiet even when I was desperate to speak. I was now helping to make family life better for all of us, rather than hindering it.

Three years on from that first meeting, the difference in home life is huge. It is far from perfect, but we can all live with it. We all just want him to feel happy and loved, and I reckon we are well on our way to achieving that.

To conclude, on a personal note – Michelle

As a professional, I learned many important lessons in working with this family. I learned how gentle and deeply humane the principles and applications of the non-violent resistance model are. The family and I learned to encompass the principles with flexibility and to understand the robustness of this method. I learned that it works, with persistence, even when we did not seem to really get it right from the start. We also learned how enriching and rewarding the experience was in reaching a point of 'joint working' as a result of the seemingly natural flattening of the therapist/family hierarchy. This experience was one reported by most of my practising colleagues. This work confirmed my long-held belief that, as human beings and families, we are capable of much more change and recovery than we at times credit is possible. We should end with Michael's comment. He has verbalised that he is so much happier with the situation at home now that violence is a thing of the past. It has been a real privilege and a joy to work with this family.

Note

1. Non-violent resistance does NOT recommend or expect parents to undertake a 'Gandhi moment' of this nature. Generally adults or carers are guided to ensure that they keep themselves safe – they can always return to address the behaviour 'when the iron is cold'. In this instance, the action and courage of his father did have the desired effect on Michael – but this action is NOT the norm.



Michelle Shapiro is a clinical psychologist who worked within Oxleas CAMHS when the approach first reached the UK. Michelle was one of the founder group who began to use it both on an individual family basis, as well as the emerging multi-family group program. Michelle has recently retired from Oxleas, and now works with Partnershipprojects and in private practice.

'Strike when the iron is cold': *Non-violent resistance in a child and adolescent psychiatric ward setting*

Nick Goddard

Non-violent resistance may seem a strange choice in the setting of a psychiatric ward. Parents are not continually physically present during an admission; there are mental health professionals on the ward trained to deal with violence and aggression; the reason for the admission is usually a severe problem. But are these reasons not to use the approach in a ward or are they challenges to overcome?

A ward, like a family, is a system. Unlike a family, there are more than one or two direct caregivers. It is important in an inpatient setting that there is a unifying vision of care and that all members of staff implement this vision in a consistent manner. Violence and aggression can develop and the team needs to respond to hostility in a way that promotes safety but also supports a young person developing less-aggressive behaviours. One way of maintaining a safe environment is to have rules governing behaviour and strategies to manage aggression, such as restraint or seclusion. However, it is debatable if such measures help a child or adolescent to develop other skills. Most psychiatric wards struggle with this dilemma.

On our wards in Amsterdam, the Netherlands, we chose to implement non-violent resistance with the aim of decreasing violent incidents, whilst promoting safety. This required some adaptation of the approach for use in a ward setting and also making many mistakes! My aim here is to highlight how it can be used in inpatient situations and hopefully to help others not make the same mistakes.

1. First agree a goal

A team needs a reason to start using the approach. Simply telling them that it is a good idea is a strategy doomed to failure and the motivation of a team is not necessarily the same on every ward. On our acute-admissions ward, the agreed aim was to decrease the use of seclusion; on a children's ward, the aim was to improve the ward's relationship with parents. Decreasing the rate of violent incidents, decreasing the rate of staff sickness, changing parent visiting-hours are all examples of goals agreed by teams. Change is frequently coupled with resistance. In the initial phase of introducing the approach or training the team, one of the following will be heard: "But we do this already", "It won't be safe", "You can't do this with someone with (fill in an illness here)". Teams can quickly feel deskilled and it is important to support them. The use of non-violent resistance should be seen as something extra to add to the toolkit and not as something to replace everything.

Adopting a motto can help a team, e.g. "Strike when the iron is cold". This gives a team a slogan and a common purpose. Agree a goal, find a reason to try the approach, adopt a motto and support the team.

2. Rules, rules and more rules

An inpatient setting needs some rules, but how many? Which rules are really needed? Does every staff member maintain the same set of rules? Does everybody know what all the rules are? The answers are: few rules are needed; most rules are not actually written down and consequently everyone has their own version, which means they change with every nurses' shift-change. The outcome is that 'rules' are frequently inconsistent. In order to use non-violent resistance, everyone has to work together and all staff members need to be clear about which rules are essential and non-

negotiable and which behaviours are unacceptable but not a reason to press the alarm button. In an early stage of introducing the approach, it helps to get everyone in the team to write down as many rules as they can that they believe exist on the ward. The result will be a very long list! This inventory

of regulations is where many aggressive incidents start; e.g. a discussion about whether you can drink cola with your breakfast, which quickly can grow into a heated argument and spill over into aggression.

The next stage is for a team to agree on key rules necessary for safety on the ward. On our acute ward, we ended up with three rules: no drugs or alcohol on the ward, no sexual behaviour on the ward and no aggression. Other behaviours may certainly be seen as unacceptable but not necessarily a reason for an immediate active intervention. We make it clear we do not accept the behaviour and then choose to delay a further discussion until we are certain there is little chance of escalation – 'strike when the iron is cold'.

3. Delaying a reaction

Mental health practitioners find it hard to delay a reaction. They want to discuss things and, where necessary, intervene. The problem here is that such discussions can quickly escalate and erupt into violence. There is a time and a place for a discussion and usually that is **not** when someone is irritated. Non-violent resistance is about preventing violence and thus not initiating an escalating cycle. Helping staff change this pattern is difficult. They feel powerless if they do nothing. The key here is to help them

**Agree a goal, find a reason
to try the approach, adopt
a motto and support the
team**

realise the approach is not about doing nothing; it is about making choices.

A central misconception is 'the illusion of control'. In order to maintain control over the behaviour on a ward, we have to respond directly. A quick reaction works well with positive rewards but, when dealing with aggression, it can lead to escalations. We have little control over the behaviour of others, but we do have control over our own behaviours. Non-violent resistance helps staff in making a choice about how and when to react. The aim is to help a young person learn other behaviours besides aggression. A consequence may be needed, but we have control over when that should occur.

4. 'if.....then....'

A frequent phrase heard in any setting is "if... then". "If you don't stop shouting then you will have to go to your room": logical, but potentially escalating. The aim is to make it clear, shouting is unacceptable. What a child or adolescent hears is a threat about being forced to go to their room and, consequently, the behaviour continues or escalates. Using non-violent resistance helps staff form the message, "We do not accept shouting". If necessary, it is repeated. It is possible to

combine this with looking for solutions, but with no discussions about consequences and no discussions about the reasons for the behaviour – this can always happen later 'when the iron is cold'. Sometimes, the most helpful thing to do after giving the message, is to say nothing. Silence is a powerful way of communicating in a non-violent manner. It exhibits presence but it is difficult to argue with someone who remains respectfully silent.

5. 'We....'

'We' statements are more powerful than 'I' sentences. 'We...' radiates the idea everyone in the team is standing behind the plan. 'I...' has less strength and less presence. It is certainly strange to talk in the first-person plural (we), but aggression often occurs in a one-to-one setting. In order to make the approach work, the whole team needs to work together. This leads to an interesting discussion – how many teams are there on a ward? The answer in most cases is usually at least two if not more: the nurses (the people present all the time on the ward who do most of the work) and the other staff (psychiatrist, family therapist, psychologist, teacher...), with further subdivisions possible. 'We...' helps define that there is one team, and only one team. Non-violent resistance can help a team develop this vision. The 'we' can be broadened out further to include parents, family members and also the rest of the organisation. It is important during an admission that parents remain present, not necessarily physically present, but they let their presence be felt. Ironically, many psychiatric wards work against parental presence by having strict visiting rules – possibly only once a week. Parents should be invited to the ward and, during moments they are not visiting, presence can be exhibited through letters, telephone calls etc. It is important to work with the parents and also to support the parents in finding supporters. An obvious statement but the experience of many parents during their child's admission is one of not being included.

6. Openness and transparency

When using non-violent resistance in non-clinical settings, it is much easier to talk about openness, for example, to tell the whole family if there has been a violent outburst. In a clinical setting, you run into the problem of a patient's right to privacy. If a young person has cut herself or himself on the ward (a form of aggression but directed inwards), the chances are the other patients are already aware of what happened, with possible concerns about safety on the ward. As the responsible professional, however, you have no right to openly discuss a patient's problems. Yet, the ward is responsible for creating a safe atmosphere. This approach can help with this dilemma. We begin and end each day with a ward meeting in which incidents are discussed within the limits of privacy, for example, "Yesterday there was an incident on the ward where a chair was thrown" and then, importantly, "We take this seriously and are looking for a solution". The violence is not left shrouded in secrecy and it is clear that, as adults, we are present

and responsible – thus promoting safety. The concomitant part of this openness is also to inform the group when a solution is found: "Two days ago there was an incident with a chair. We have now found a solution for this problem and the incident is closed". In the intervening period, there will

always have been a discussion with the young person involved (at a time when they were quiet and not angry) and they have been asked to come up with a solution. In some cases, the young person themselves will present that to the group.

The above points are not specific interventions but more how non-violent resistance principles should be used in determining the overall vision on the ward. It is important every staff member adopts these attitudes. Our experience is that this form of non-violent demeanour accounts for about 75% of the success of the approach, though it should not be underestimated how much support a team requires to master the principles. They are used in conjunction with a few specific interventions.

7. The reparation act

The reparation act is a way to repair something that is broken. During an aggressive incident, things can get damaged – not just physical damage but the sense of trust or safety. It is important to be able to look for a positive way of repairing the damage in a manner completely different to the aggression itself. Saying sorry is one such, but a young person may also choose to write something or bake a cake; the list is endless. It is important the action leads to a change in behaviour. Saying sorry after each incident in a pattern of behaviour is not an acceptable reparation act. Usually, this discussion takes place when everything has cooled down. "Yesterday, you were swearing and shouting at the teacher on the ward. We take this seriously as we don't accept swearing on the ward. We think it is important to be able to resolve this problem. Do you have an idea what you can do to fix this?" It is possible to think together with the young person about possible solutions. If the young person refuses to do anything, it is possible for a team member (or a family member) to undertake an action in the name of the young person. For most young people, this is a completely different way of thinking and

We have little control over the behaviour of others, but we do have control over our own behaviours

acting. It can help them think about other less aggressive ways of behaving. This is, of course, not always successful and is certainly no instant solution.

8. The announcement

Whenever there is a repeated pattern of behaviour and other interventions have had no effect, then is it possible to use an ‘announcement’. This is a written statement about behaviour that we can no longer accept. It is important this is not just a message about negative behaviours. The announcement begins with a positive point about the young person and then names the unacceptable behaviour coupled with a declaration that we will look at all possible solutions. The announcement is usually read out to the young person (during a ‘quiet’ moment) and a copy given to him or her. The rationale is to let the young person see we will resist the aggressive behaviour, though are not planning to use violence. At that moment, there is no discussion. If the young person wishes to think further about change, it is possible to plan a meeting to discuss these ideas. An announcement is usually coupled with the next intervention – the ‘SMS’.

9. The ‘SMS’ (silent-message sending)

When training a team, the silent-message sending is usually the intervention that evokes the largest response. It is a powerful display of ‘presence’ without using aggression, but is also one that asks a lot of the team. It is based on the ‘sit-in’. In a ward setting, there is almost no way members of the team could perform a sit-in lasting an hour. We have adapted it so it is still an extraordinary act but it fits realistically into the team’s capacities. It is used whenever all other attempts to find a solution have not worked. It is preceded by an announcement. Three members of the team carry out the intervention, with a fourth person on the ward. Three for us is a significant number. Each shift, there are two nurses. How is it then possible to find four people? The team is, of course, larger than the nursing staff. Other members of the team also participate. It is possible to carry it out together with parents. The silent-message sending lasts 15 minutes, once more a significant amount of time that represents a major use of staff. The three people go to the room of the young person and sit down on the floor. The leader makes a statement: *“We are not prepared to accept (the behaviour is clearly named). We are here to look for a solution and will remain sitting here until a solution can be found”*. After that, there is silence and the staff members maintain this silence. If the young person tries to provoke a reaction, this is also met with silence. If the young person suggests a solution, this is accepted and the sitting is stopped. If, however, the solution has already been tried, then that is declared and the intervention continues. At the end of the 15 minutes, the leader announces no solution has been found and the team departs. During the sitting, the young person is free to leave the room. If this occurs, the fourth member of the team is present on the ward and more actively supports the young person to return to the room or to think about a solution.

The silent-message sending is complicated and it is difficult to give a full description in a summary such as this. The aim is to bring about a change in behaviour by our demonstration of our commitment and preparedness to do something beyond what is expected. If a solution is forthcoming, that is a welcome surprise.

Fears about an aggressive reprisal from the young person are mostly unfounded. It is hard to be aggressive when there is no escalatory response. Usually, the young person is surprised by the action and may ask some questions, or will reply by ignoring the team. Of interest is the effect on the young person, who continues to think about it long after it is ended and often refers back to it as a motivation to change their behaviour. A lot of work is needed with a team (and parents) to help them be in a position to carry this out. It is in many ways the embodiment of non-violent resistance, though, in our experience, an intervention we seldom have to use.

Conclusion

Every ward sets out to help a young person. Unfortunately, some of our ways of working can contribute to the violence and aggression. The reality is that we have little control over the behaviour of others. Non-violent resistance can help a team find a new way of working whilst also promoting safety and decreasing violence. Some of the ways to adapt the approach for use in a ward setting are set out in a pragmatic way in this article. There is of course much more to say and further ideas about the underlying systems theory. Parents are, of course, essential and should not be marginalised during an admission. Since introducing the approach, we have seen more than a 50% reduction in aggressive incidents on our wards. However, in itself, it is no panacea. It helps staff gain another perspective, an additional tool to use. It is a strange choice, but psychiatric wards are strange places!



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Becoming a quiet leader: *Non-violent resistance therapy with the parents of learning disabled young people who have become violent*

Alex Millham

The lessons of my work with violence and learning disability are simple: keep the approach clear, don't accept aggression is inevitable and don't forget there are other approaches to use. In this article, I use examples from my work over the past five years and place non-violent resistance in the context of other approaches that encourage parents to do something different.

Manage expectations

Where a young person has a learning disability, the expectation of those around them might be that violence is inevitable or understandable. This might lead to its acceptance. More common, in my experience, is that parents might wish their child to be different and not fully appreciate the level of difficulty they may have. This, of course, can be painful to consider, as their hopes and dreams for the child may not match with what is possible. Several of the parents have not connected their child's difficulties with their learning needs, despite knowing that, in many respects, they are younger than their years. Often, work cannot move forward significantly until the parents have accepted the level of difficulty their child may have, at the same time as understanding that violence is not acceptable. For one parent, this led to acceptance that their daughter, despite being a teenager, would take things to school (like teddy bears) that mum felt were inappropriate. She stopped some daily conflicts by no longer searching her bag and battling over what went into it. Parents can learn to manage behaviour differently and young people, in turn, can learn to manage their feelings differently. However, where children have a developmental difficulty, not everything will be changed by therapy.

Saying less and doing less

Work tends to begin with an introduction of common escalation patterns between young people and parents (Haley, 1991, Omer, 2003). One pattern is of symmetrical escalation, where the parents and young people can become locked in battle.

Mark, aged 13, took his brother's toy gun and repetitively shot him with the small balls. In his attempt to gain control and keep his younger son safe, Mr Gardner first asked Mark to stop, then shouted and later tried to take the gun from him. Mark refused and a wrestle began. Mark became enraged; he began throwing things and hit out at his father. Mr Gardner went downstairs and locked the front door to prevent his son from leaving. Mark heard this, ran to the door, and then kicked it. Next he ran to his bedroom window and attempted to climb out. His father held on to him and was kicked again. Things calmed when friends walked by the house, heard the struggle and came into the house. Later, Mr Gardner learnt to de-escalate similar situations by quietly removing the younger brother and not attempting to restrict Mark. This became easier to achieve when he knew he would be addressing things when everyone became calmer.

At other times, parents might have avoided confrontation by 'treading on egg shells'. Non-violent resistance can represent a middle way, a means to address unacceptable behaviours without either getting into a battle or treading on eggshells. This begins with learning de-escalation skills. With children with a learning disability, this can become a considerable challenge. Not only can they want immediate answers, as with many teenagers, but they can also be remarkably tenacious in following parents around and repeating the same things over and over.

This approach advocates a delayed response from parents. De-escalation, alone,

can feel to parents like they are avoiding things and letting the child get away with them. A delayed response may begin with parents talking with the young person after things have calmed down. This will not be in the form of a long discussion or analysis but telling them, for example, that hitting is wrong. A calm, considered parental authority can emerge through coming back to things later. This fits with other systemic approaches (Watzlawick et al., 1974; Cade, 1994) and other related approaches to managing teenage behaviour (Weinhaus & Freidman 1988).

Parents need to be clear

An announcement offers the formal start of a parental campaign against the violence of their child. It outlines clear expectations from the parents and sets out some of what they will do. Whilst learning the approach, I became accustomed to a fairly lengthy, sombre announcement. With this client group, I have developed a simpler approach. Here is an example:

*The violent things you do are wrong.
They make us feel upset.
We don't want to live like this any more.
We will try to change this.
We will not smack you or hit you or get into arguments with you.
We want these things to stop:*

- 1. Hitting other people*
- 2. Throwing things at people.*

*If you do these things we will tell important people like Nan, Grandad, S, Mrs W and R.
We will always be here for you.
We love you and always will, no matter what.*

There are parallels with the use of social stories (Gray, 2010) in this approach, which is often used with young people on the autistic spectrum to explain things in a clear, unambiguous way and set out the effects of a specific behaviour upon other people.

What is often most important in delivering social stories is that parents remain persistent and calm. An announcement requires similar tenacity. The reading of an announcement is a time to practice de-escalation and calmness. Young people on the autistic spectrum often live in a world of right and wrong, and being clear through describing what behaviours are wrong is useful. A 'less is more' approach to the announcement involves reducing the number of words and reducing the complexity of the language. At times, parents have chosen to add pictures, or to spend longer sensitively considering the appropriate use of words that might be better understood.

A 'less is more approach' also applies to parents where they might experiment with using fewer words in other situations. More words from parents can lead to more words from the young person and end up in escalations that begin as unhelpful debates or dialogues rather than addressing what went wrong. Parental attempts to reason with, to explain things to, or to lecture them often end up as counterproductive (Cade, 1994). Using fewer words and using words more carefully has been a key part of the approach.

Prioritising

Challenging behaviours are common with young people with a learning disability. However, parents cannot target all such behaviour. Initially, narrowing the focus of the work can help reduce tensions in the household. We remind ourselves, and sometimes our clients, that Gandhi used a seemingly small issue to mobilise feeling of injustice against the British, most famously by publicising the unfairness of a British-imposed tax on salt. A success in a small area can lead to greater confidence for parents but may also lead to a better life for young people too. Young people may feel less nagged and parents may stop being on their child's back all the time.

Jack was ten and diagnosed on the autistic spectrum. Family conflict would regularly escalate to the point where his parents would restrain him. Some days they would describe this as successful; other times they would come out of it bruised and exhausted. They struggled to conceive of a way of managing his behaviour without resorting to physical methods. Prioritising what to start on meant that the areas of conflict were reduced. An example was the nightly battle to get him to clean his teeth. Once it was decided this was not the target of the work (instead, this was

around his violent behaviours) much of his behaviour calmed down as this particular struggle stopped. His parents were not totally ignoring it. Instead, they would say something like "It's bed time, remember to clean your teeth" and perhaps later on they might say "We were disappointed to see you didn't clean your teeth last night". What they were not going to do was insist he cleaned his teeth because, every time they did this, it led to a battle and, moreover, the battle was not effective at getting the teeth cleaned.

In showing a calm, clear approach, the parents demonstrated restraint in their behaviour rather than seeking to physically restrain their son. This later became unnecessary. This is not to imply the parent's behaviour was the cause of his violence. Their son clearly had a difficulty in managing his emotions and behaviour both at home and school. However, the parents stepping out of their usual role left the son needing to find something different to do. Once the household is less at risk of exploding into violence, smaller issues (like teeth-cleaning) often become less important and seem to resolve themselves or parents feel more confident to tackle them. Handing some responsibility to the young person can offer them the opportunity to learn, to make mistakes and to learn to manage frustration differently.

Role-play

Particularly when parents find themselves stuck in escalation patterns, I will often invite the family to role-play the current situation and practice alternatives. Parents, like most trainees, tend to feel embarrassed at any suggestion of role-play, though later finding it useful. As therapists, it is crucial we ourselves convey our confidence in this approach, even when we feel somewhat awkward. As our work is usually with parents, role-plays do not tend to involve the young person.

The Morrison family came for a third meeting. Present were the mother, grandmother and the referred boy's two teenage sisters. They described a repetitive pattern at home where things would quickly get out of hand. After several unproductive attempts to talk about this, we invited them to show us what normally happens at home (with me as the young person). They described the young man entering the lounge and demanding money from his mother. She would do her best to ignore him when his demands were unreasonable. His older sister would attempt to back her mother up and

then take over by telling her brother off. This attempted support made things worse and would lead to him throwing things around and swearing. After this demonstration (and after much giggling) we asked everyone what, on reflection, they would have liked to have done. The daughter, who was studying a course in animal care, thought about how dogs want to be leader of the pack, and felt that both she and her brother were vying for that position. The mother felt she should be the leader but, following the mindset of peaceful presence, wanted to do this quietly. We then asked them to show us again what they might have done, just as an experiment. The sister was able to say less, and I, as the boy, found it harder to argue, as I had little to argue with. The mother preferred this and felt more able to deal more calmly with the situation herself.

Family therapists might note similarities to the enactments favoured by structural therapists (Minuchin, 1974). Where families feel stuck for alternatives, we might make suggestions. These may include strategies like saying less, keeping a safe distance from the child, speaking more quietly and reminding that things can be dealt with later. I continue to be surprised by the openness family members show when engaging in role-plays and their ability to experiment with trying different things.

Non-violent resistance and the life cycle: parental presence and positive risk-taking

Parents seek to address the violence whilst leaving the young person free to make other choices. This may be in contrast to approaches that seek to constrain, restrain or exercise control over young people. They become a presence in young people's lives but not in a domineering position. It is a typical task of development into adulthood that children become able to experiment and learn to make their own choices. The balance between independence and dependence is often more complicated for parents of young people with a learning disability. I have often met parents who, for good reasons, struggle to allow their child more independence. Others expect their child to develop more quickly than their abilities allow. The young person's age might be at several different stages, for example, in terms of intellectual ability, their chronological age and social ability. These differences can be confusing and hard to recognise as they may become skilled in some areas but not in others. One parent described a daughter as interested in

make-up at the same time as liking cartoons for pre-school-aged children. They might also have learnt to adapt to their limitations, for example, in relation to difficulties with language or social situations. Positive risk-taking might involve a child walking home from school with a friend or going to the park without a parent.

Keep the warmth

Once violence takes place between children and parents, the relationship can become, as it were, a battle for power and control. However, attempts to enforce increasingly tougher sanctions worsen the situation. This cycle is potentially self-perpetuating, as neither party will wish to back down for fear of showing weakness. Effectively, this violence robs both parties of the relationship they need. Relational gestures offer a potential way out of this stand-off. They invite parents to consider small gestures that seek to make peace, or return a nurturing element to the relationship.

Hannah's violence towards her father had become so unbearable that she moved into a temporary placement in a children's home. One incident had resulted in the father being burnt when she threw hot cooking oil over him. Hannah's level of understanding meant that talking about incidents was mainly unproductive. Her parents' visits to the children's home would be difficult, with Hannah appearing rejecting of them and them struggling to find a way to engage with her. In order to break this pattern, and after much thought, her father decided to buy her a teddy bear. He chose not to present it in a grand way but merely to leave it on her bed. On finding the bear, she became excited and curious about how it had got there. The teddy bear changed the relationship. It renewed a loving parental presence in the life of the child in a way that surprised and moved her.

Violence impedes relationships and so it is useful to improve relationships as well as address behavioural concerns. An improved relationship is not always the focus of behavioural work but is often what parents most wish for. In sidestepping control of the violence, parents at times reclaim their own preferred role as a parent, in spite of the behaviour of the young person.

Keep connected

Families with children with a learning disability can be socially isolated. Parents may feel, and their experience may



Alex Millham pictured at the UKASFP conference 2013. ©Jenny Gavin-Wear – Photographer www.jgw-photography.co.uk

be, that their child's disability makes friendships harder. Add to this that their son or daughter has become violent and this may make the prospect of building relationships feel like a risk. This scenario can make the role of supporters important. Supporters may be enlisted from friends or family, for parents to speak with, to come to the house, to share successes with or to contact the young person as part of a message campaign. By reducing the sense of isolation, parents may feel more that they are in a community of concern and feel a greater sense of confidence.

Logic of control and the therapists

The approach in this article suggests that strategies for addressing violence in family life can be considered alongside issues like the life cycle and positive risk-taking. Non-violent resistance work can be complemented by use of social stories, clear expectations and understanding of their child, their strengths and areas of limitation. The experience of being hit, punched, verbally abused or kicked should not be underestimated (Holt, 2011). It can make it hard for parents to mobilise their own energies in a positive way. If we don't acknowledge the effects of violent behaviour upon parents, we risk them being unable to attempt something different. When given a set of tools such as those that this approach offers, it can be tempting for the practitioner to use them in an

indiscriminate way. Non-violent resistance offers a philosophy alongside several techniques. For parents, this includes the belief that they cannot control their child and any attempt at control is likely to lead to a battle that nobody wins. Instead, it begins with self-control. It may be useful for therapists to remind themselves of this philosophy in relation to their clients, in particular to step away from a struggle for control. A more fruitful therapist position may be one of gentle persistence alongside understanding that you can only control what **you** do.

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Using announcements within a multi-cultural/faith context

Shila Desai

All names and identifying features have been changed to retain client confidentiality.

This article explores one aspect of the non-violent resistance approach: the announcement. In the case example, it becomes a tool to regenerate relationships across potential barriers of culture, race, language, shame and secrecy.

I work as a family and systemic psychotherapist as part of a citywide, Birmingham Tier 3 child and adolescent mental health team. Frequent referrals for non-violent resistance therapy come for adolescents diagnosed with conduct disorder and/or attention deficit hyperactivity disorder. In these cases, aggression and violence have paralysed their caregivers and created hopelessness, not only within the caregivers, but also within the professional system. Many areas of Birmingham are economically deprived, with high levels of poverty and unemployment. Some parts have a population of black and minority ethnic communities, which is above the national average. It is within this context I have begun to use this approach.

Clinical context

I recently began work with Shazia, a Pakistani mother in her 30s, who had come to our service due to the increasing aggression and violence from her older son, Quasim, 15. This was impacting on both his relationship with her and his younger brother, Ali, who had been diagnosed on the autistic spectrum. Trivial arguments between the siblings would escalate and lead to Quasim hitting or pushing Ali. Alongside this, Quasim would make financial demands of his mother and become threatening and aggressive if she refused.

Social isolation and trauma seemed key aspects of Shazia's narrative. She had experienced her husband as violent and unsupportive, and she had become isolated from her extended family for reasons she could not share. She felt hopeless and feared she could not raise her own children. Initially, this led to her own aggression and shouting, and later, to giving in and giving up with both her children, a shrinking of her presence as a parent.

The writing of the announcement

The announcement acts as a vehicle to *"authorise direct non-violent action and utilise a social support network"* (Jakob, 2013). In this case, the announcement needed to act as a bridge to connect child-parent-family and professional helpers in the struggle and commitment to act differently. The announcement was written with Shazia, an interpreter and myself, in a clinic setting. We also had a reflecting team, composed of the psychiatrist and community psychiatric nurse, who could then be 'participants in the process' (Andersen, 1997). Through their reflections, Shazia was able to experience how the network accepted both her ownership of her own escalations, and her commitment to change, as an act of resistance and power. The professionals' reflections

of her strength and her commitment to her son were written by myself in English and translated into Urdu. Statements such as, *"I have courage"* and *"My son needs me"* thus acted as 'supporters' beyond the therapy room.

The role of helpers

Many attempts had been made to engage helpers to join Shazia in the work. She would brush questions about these aside, telling me that her family and friends were too busy. She always came alone. The announcement was initially written by myself in English and given to Shazia. We asked if she would be able to get support to have the announcement translated, as the interpreter had to leave early. She agreed to ask her brother, who lived locally. We offered to join her in the delivery of the announcement, due to her fear. From a co-ordinated management of meaning contextual framework (Cronen & Pearce, 1985), the written act of the announcement became a relational act to redefine family and professional relationships.

The delivery of the announcement

The following week, the community psychiatric nurse, the interpreter and I joined Shazia in the delivery of the announcement at her home. I met Quasim for the first time and, as is often the case, he was a friendly young man, watching TV. Whilst Quasim was in one room, we met Shazia in another. She took out the announcement, written in Urdu – her brother had helped – and she read it in Mirpuri, the 'mother tongue'. Just before making the announcement, we role-played the reading, with myself as Quasim, to make sure she was prepared for any possible difficulties and that there were no unnecessary escalations in its language. The interpreter was extremely active and alert to both our languages at this point.

Shazia began to shake and giggle nervously. Trauma and dis-regulation manifests in the context of violence, and she was genuinely terrified. We used some grounding and breathing techniques to relax her. We then asked her to consider and experience a 'safe other', which, for Shazia, was 'Allah'. I saw her posture change; she was ready to face what was, in her experience, the 'battleground', as she announced violence was unacceptable.

Quasim was invited into the room. He sat on a chair by himself in a corner. His mother Shazia read the announcement slowly and calmly to him. I noticed her strength growing as she continued to read and Quasim listening intently. The atmosphere in the room had a different quality as both mother and son were participating in a mutually significant exchange.

At the end, I gave Quasim a copy of the announcement in English. He re-read it. He then said this took a lot of strength from his mother and he liked it. We asked him what he liked and he said she had written that she 'loved him'. Quasim came and sat close to his mother.

The announcement became more than a statement that the violence needed to stop. It created an opportunity for the forgotten stories of their relationship to unfold. Quasim's expression of his need to be close to his mother came through the exchange of the carefully chosen words in the announcement. Her delivery showed her strength not to be overwhelmed any more by his demands. The session continued, and considered how they could both become closer to each other and a reconciliation gesture was carefully planned. As they began planning to watch TV, what came through were 'small acts of resistance to oppression' by Quasim, as in helping his mother understand English through a TV programme and through his own non verbal gestures he was showing, "I want you close".

Gandhi suggested using 'non-violence' through the application of 'Satyagraha', or 'soul force', which he describes as the means to wean opponents from error through patience and compassion. This is the beauty for me of using non-violent resistance in a family-systems context, as through practices such as announcements, both the oppressor and the oppressed benefit.

The role of the interpreter

Non-violent resistance provides a concrete framework that is accessible to working across languages. The clear and methodical process of writing a structured announcement works extremely well across languages and can be understood and explained through verbal and written translations of both the intentions to resist and the 'acts' against violence. So far, I have met Shazia on three occasions and, each time, we have had a different interpreter. I noticed each interpreter instinctively understood what was required. However, these are some suggestions to keep in mind:

1. Sit close to the parents or carers so you have direct eye contact and connection with them throughout the creation of the announcement.
2. Have an English version of the announcement alongside one in the family's preferred language. It is likely that the child or children will not be able to read in their 'mother tongue'.
3. When role-playing or delivering the announcement, the interpreter sits close to you and acts both as a translator of the language and of the emotions, for example, checking with the interpreter as the announcement is being delivered whether there is an escalation or too much pontification by the parent, in speech or tone.
4. A shift in pace of interpreting is required. Writing can take time but in the delivery and role-plays, speed is essential and this requires great skill and tenacity in the interpreter-therapist-parent relationship.
5. Encourage direct communication between the child and the parent(s), if possible; e.g. in feedback from the child or planning of reconciliation gestures, and use the interpreter to translate both child and parent(s) to the therapist. It is important, as newer more hopeful dialogues develop, to reposition ourselves as witnesses and use the interpreter to translate the direct parent-child conversation to us. This enables the process of increasing parental presence in the moment.

Conclusions

I have given an example of an announcement as one aspect of non-violent resistance that has great potential to influence discourses around culture and the relational aspects of therapeutic

approaches. The practice of finding the right words, role-playing and being a supporter delivering the announcement, used every aspect of the 'self', and highlights the 'relational risks' (Mason, 2005) taken by parents, carers, children at their most vulnerable, in trusting this way of working with professionals across so many barriers. Divac and Heaphy (2005) describe the importance of the exploration of cultural competence for therapists and I would argue that the practice of this approach, the principles of which are rooted in activism, brings forth very quickly those voices that have been subjugated. Supervision and post-reflections are essential to give voice to these experiences.

I thank Shazia and Quasim, and am humbled that they had the courage to enable us to hear their 'quieter' voices.

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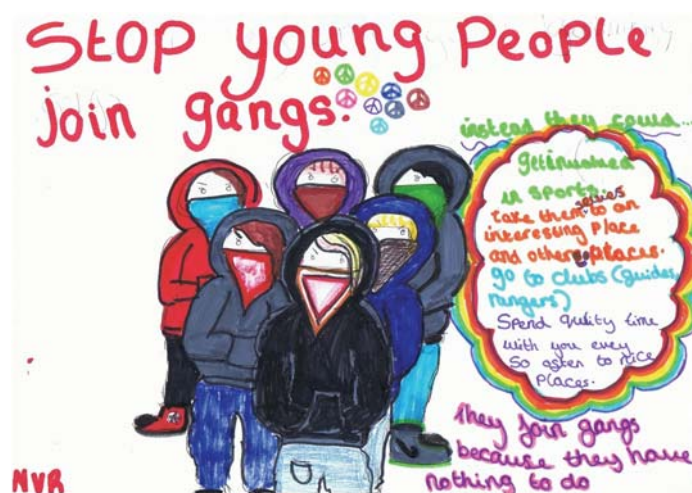


Shila Desai has extensive experience as a family and systemic therapist and supervisor in Birmingham CAMHS and has a lead role in developing the non-violent approach across the city.

Application of the non-violent resistance approach to gangs

Elisabeth Heismann, Dorota Rospierska and Helen Weatherley

The UK riots in 2011 reminded us violence could be on a scale difficult to comprehend. Gangs and gang culture became a topical issue. Professionals had to consider the reasons young people commit acts of violence and why they take part in organised groups, involved in crime or antisocial behaviour. The "Violence in the Community" non-violent resistance parenting programme was created in order to address youth gang-violence. The programme has been intended to help parents and professionals manage their response from a non-violent position.



How the gang group differs from our other groups

The 'violence in the community' group has three stages.

The **preparation stage** consists of home visits. Owing to a long, sometimes difficult history of involvement with professionals, many potential participants have issues around trusting workers. We had to build trust gradually through home visits before the parents would be ready to join the group. We discussed potential obstacles to their attending the group, such as their concerns that their children's identity would be revealed against their wishes.

The **delivery stage** was thirteen sessions (not ten, as in other groups). Each session had an educational element in the form of presentations from representatives of organisations who are involved with the target group (such as the ex-gang members turned mentors, youth offending service, violent organised crime unit, education, substance abuse services). This gave parents an insight into the young people's world via experiences of people who work with the children on a daily basis. In generic groups, the emphasis is on creating a strong, versatile multi-disciplinary team who work well together as facilitators. In the 'gang group', the emphasis was on creating a support network of professionals around the facilitators' team. It came together for regular steering-group meetings and stayed in close contact with the referrers and other professionals involved in the lives of the participants' families.

The **evaluation stage** was completed with the research team from Westminster University who conducted an independent qualitative study, exploring the experiences of the completers, non-completers and dropouts from the programme.

Brenda's story

Brenda was rather bemused when a facilitator called to arrange a home visit. Although she was concerned about some of her son's behaviours, such as the fact he had isolated himself from the family, she was adamant he was not involved in any gang activity. However, she agreed to come to the group, as it sounded interesting. As the weeks progressed and her knowledge of gang activity increased, she began to identify elements of her son's behaviour that led her to believe perhaps he was involved, after all. She later found weapons belonging to him in his room, and things began to change. She started to use the skills she was learning on the course and soon began to see a change in the relationship between herself and her son. He has now returned to full-time education. He is counselling friends and encouraging them to keep away from gangs. Brenda will be part of the team that is presenting our work during the Third International Non-violent Resistance Conference in Munich in 2014.



Gangs and sexual exploitation

Many parents have become anxious about the infiltration of gang culture among children. Girls as young as in their final year at primary school have been targeted by gangs, and contacted by older boys on Facebook. We recognised a connection between sexual exploitation and gangs, and have recently completed a pilot programme targeting sexual exploitation of children.



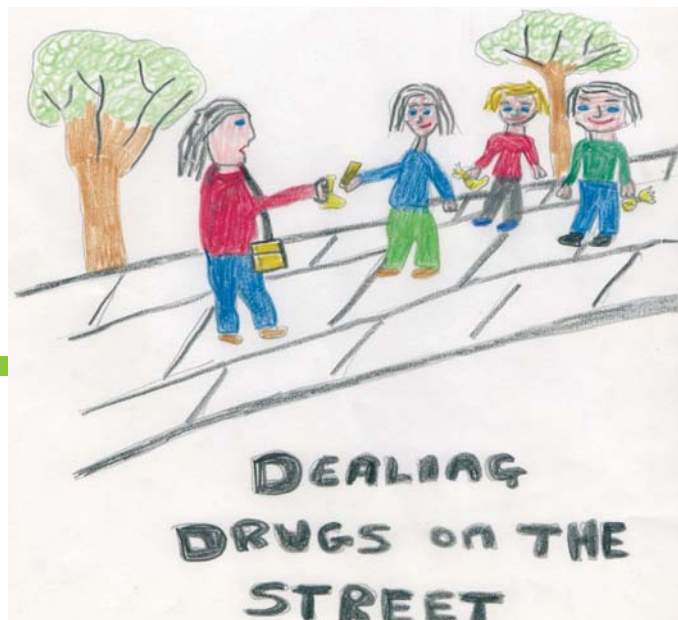
The parent facilitators' views on the specialist non-violent resistance group

- I was struck by how different the parents seemed from the parents on the generic non-violence resistance course. A 'typical parent' on the generic course seems broken, at the end of their tether, unable to cope and afraid to ask for help. The parents we encountered on the home visits tended to be strong, protective and defensive of their children - secretive, distrusting of professionals, not afraid to say what they think.
- This course was very challenging because of the special focus: that is why having presenters at the beginning of each session was very beneficial to the course and the parents as they received important information and had any question answered by a professional.
- The parents were friendly and always willing, but took a while to let their barriers down.
- They worked well together as a group and were very supportive of each other.

Future plans

In March 2014, during the 3rd International Non-Violent Resistance Conference in Munich, we will have presented on the application of the approach to group work in child protection, and hope to demonstrate that the approach is adaptable and applicable to deprived and complex families.

We would like to close with a quotation from one of the parents from the gangs group last year:



"Parenting doesn't come with a book; people are just trying to help you be the best parent for your child. It's not about judging you as a parent or pointing the finger, so just give it a go."

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Rosie-May McClay is the young artist who did the drawings used in all the reports from the Oxleas' projects. Eve Weatherley (aged 11) has also contributed a picture used in this article.

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The authors of the report

The unmet needs of the child in non-violent resistance: a developmental-dyadic-psychotherapy approach for families

Denise Wilson and Margaret Smith

Power is of two kinds. One is obtained by the fear of punishment and the other by acts of love. Power based on love is a thousand times more effective and permanent than the one derived from fear of punishment.

(Ghandi, 1925)

At the first international non-violent resistance conference 'Beyond Behaviour' held in Greenwich, London in April 2011, Haim Omer presented his new vision for linking non-violent resistance to attachment theory via the concept of parental presence as an 'anchoring function', to build on the familiar attachment ideas of the safe haven and secure base. The image of the anchor, as well as representing the ongoing link between the parent and child, was also to act as a conceptual bridge between parental authority, non-violent resistance and attachment theory (Omer, 2011).

This focus on attachment and, indeed, the whole theme of the conference in looking 'beyond behaviour' towards the underlying unmet needs of the child or young person, resonated strongly with our own experiences at work, where the emphasis of our interventions had been shifting radically from behavioural to attachment and relational-focused approaches. Additionally, with our non-violent resistance practice, we were venturing into, for us, new waters by preparing to embark on group work, inspired by the pioneering work of Liz Day and Elisabeth Heismann from Oxleas CAMHS (2010) and our colleagues Rachael Aylmer and Alex Millham in Portsmouth. In this article, we describe how our growing focus on attachment, and specifically our increased use of the dyadic-developmental-psychotherapy approach (Golding & Hughes, 2012), influenced the development of our practice of non-violent resistance therapy.

Our journey had begun in 2008 when we started working with a family where the violence of the referred child, a boy of twelve, towards his mother and his siblings appeared extreme, even in the context of our service, a well established tier four specialist, multi-agency child and adolescent mental health service; the Behaviour Resource Service in Southampton. It seemed a range of other approaches had been tried already so, initially at a loss as to what we could offer that would be new, we researched other possible approaches and found non-violent resistance. Peter Jakob, who had recently introduced the approach to the UK (2006), provided training to the team working around this case.

As we frequently found in our work, the controlling and explosive behaviour (in this case including firing a nail gun in the home and taking his siblings hostage), masked the extreme vulnerability and unmet needs of the child, who had experienced trauma and abuse resulting in high anxiety and low self-esteem.

Now, we would understand his behaviour more in terms of a disorganised attachment. However, at the time, as novices in non-violent resistance therapy, we stuck like glue to the approach we had learnt and performed frequent sit-ins, which the mother followed up with reconciliation gestures.

From reconciliation to relational gestures

In the approach, as we had first learnt it, reconciliation gestures are performed after the adult has undertaken an act of active resistance such as a sit-in. Reconciliation gestures are unconditional; they are not rewards and so parents persist in offering them, even if the child is ungrateful or actually rejects the gesture. This is very different from the majority of parenting approaches and it can be hard for parents to accept they should unilaterally make and maintain the gestures, alongside acts of resistance, even if the child continues to be difficult and unremorseful. However, doing this is a crucial way of demonstrating unconditional care. The parents are encouraged to enhance the impact of the gestures as symbolic representations of their parental presence and care by gearing them to the unmet needs of the child.

We found it remarkable how very powerful these reconciliation gestures were; in this case, those that involved the parent spending time with her child, through card games or watching TV together, were the most effective and clearly illustrated the unmet need of the boy for his mother's attention within the large group of siblings. This approach reduced violence in the home within this family and we continued to use the traditional format with individual families, with some successes, for a couple of years.

There had been some initial resistance in our team to the approach because of what was perceived as the child-blaming aspects and the punitive and shaming potential of strategies such as the sit in. At this time, other practitioners were questioning the child focus in the approach. Newman and Nolas (2008), for example, through discourse analysis of non-violent resistance texts, identify a strong 'war' discourse, framing the child as the perpetrator of violence on the parents (2008, p. 147) but also find a subsequent affirmation of the vulnerable side of the child as loved by their parents; a side that can be nurtured through acts of reconciliation. Peter Jakob (2011) similarly considers closely the issue of how to focus on the child's unmet needs within the approach, asking what changes are needed if it is to

Non-violent resistance: Integrating approaches – lessons from working with adoptive

achieve a child focus. One way of achieving this is, he explains, by focusing on reconciliation gestures as a key way of building the parent/child attachment.

An adult, who makes gestures of reconciliation from a position of care for the child, will be more likely to see the child behind the violence (Jakob, 2011, p. 13).

He talks of “two sides of the parent’s efforts” (p. 6) needed in the approach, saying the parents must build up emotional closeness to the child as well as their resistance to the child’s demanding and/or aggressive behaviour.

Each reconciliation gesture provides parents with an opportunity to communicate their awareness of the child’s unmet need (p. 27).

In this way, the gestures complement other ways of raising parental presence, such as when parents demonstrate active resistance by conducting sit-ins or initiating message campaigns. We also found that the potency of these unconditional gestures extended far beyond the role of reconciliation following an intervention. Interestingly, the mother in our original family called them, “love gestures”, which echoed the widespread shift in terminology from ‘reconciliation’ to ‘relational’ gestures in the community of non-violent resistance practitioners (e.g. Jakob 2011).

Over time, we adapted our approach; we found we were increasingly using fewer sit-ins and more message campaigning, eventually phasing out the sit-ins in their classic form almost entirely. We initially referred to what we were doing as ‘NVR-Lite’ within our team but, eventually, it became our approach of choice. At this time, the remit of our agency changed slightly and we began to work with adoptive families where there was high risk of breakdown. We noticed with these families that the parents seemed more detached and emotionally cut off from their children and it was therefore harder to get them to see their unmet needs. One adoptive family, in particular, made us question the way we implemented the approach and opened us up to be more creative and to develop our understanding of how imperative it is to pay attention to the child’s unmet needs.

In this family, two biological brothers had been adopted and one of the boys, Luke, had been very challenging to his parents and especially to his mother, whom he had physically assaulted. The approach seemed to ‘fit’ and the parents were out of ideas and so agreed to work with us using the approach. It became clear that the parents had lost sight of the boys’ early traumatic history and, therefore, the vulnerability of both of them shortly after we became involved, both of the adoptive boys were accommodated in local authority care, with Luke being placed in Surrey. He was placed so far away because it had

come to light he was being groomed into a sexually exploitative ring. This presented two challenges: the first was how to recruit the foster-care agency into the approach and the second was how the parents could carry out the relational gestures from a distance. The first challenge was relatively easy to overcome as the foster-care agency were interested and open to hearing about the approach we had been using. Together with the parents, we conducted a training session for the foster carers and supervising social worker; from this, we generated a shared understanding and an agreement that non-violent resistance would be the model used both in the foster-care home and the family home. The second challenge was how to implement the relational gestures when the parents were only seeing Luke monthly.

The use of relational gestures and the connection of these to the child’s unmet needs became much clearer following the parents’ sharing with us a story of disappointment at the ending of a weekend visit from Luke that had gone very well but then was spoilt. They told the following story to illustrate to us how they had failed to ‘follow the programme’. They had organised a family picnic at a local country-park and the extended family had all been present. They had spent the day enjoying how Luke had integrated with the family and noted the absence of bad language and violent behaviour; they had experienced Luke as he used to be. However, a small incident at the end escalated and Luke then stormed back to Surrey without saying goodbye.

When the parents were asked to look behind the behaviour and consider how Luke may have been feeling, they were able to hypothesise about his possible feelings of sadness, loss, anxiety, and to understand that goodbyes could have a different meaning for him. This was the turning point for the parents. They began to see things from Luke’s point of view, not only their own. They realised they had to change their responses and, when they subsequently tailored their relational gestures towards his unmet needs, the unwanted behaviours disappeared and subsequent contacts improved along with regular positive phone and text contact. This family never made the announcement they had prepared and, whilst Luke did not return home, their relationship thrived. The use of relational gestures ‘from afar’ was a key factor in shifting our understanding of the way they act to promote and sustain the relationship, their true spirit of unconditionality and their symbolic force as bearer of parental presence.

The learning from this family was paramount to our future work when we started to use the approach with groups. We used our learning from the family above to actively think how to shift the focus from behaviour to the child’s needs. We decided to incorporate the country park vignette into the group programme by the facilitators recreating the episode through role-play.

First, we divide the group in two and ask one half to watch the role-play in the position of Luke and the other half in the position of the father. This helps the group members develop the understanding that there is always meaning behind the behaviour. If they can see this can generate empathy for the child's unmet need, they are one step closer towards being curious about what is behind *their* child's behaviour. We then set the scene and enact the following:

Escalation scenario

Luke is in foster care.

The focus is on improving relationship between Luke and family when he sees them.

The following exchange happened at the end of a family contact day after which Luke would return to his carers. The day was spent in a country park and had been really positive. All family members are packing stuff into the car. Luke is carrying Dad's special camera and goes to stow it in the boot of the car.

Father: Be careful! That camera was expensive!!

Luke: [under breath] D***head

Father: What did you call me?

Luke: [louder] D***head ... d***head!!

Father: Don't you call me names like that! Loser!!

Luke: [storms off] F***ing tw*t. You're not my Dad and I don't want to be part of this f***ing family anyway.

Within the group, the role-play arouses strong feelings and discussion as to how the situation could have been handled in a de-escalatory way, and the group generate lots of insights into what both the father and Luke must have been thinking or feeling at the time. This is what focuses on the unmet needs – it was not just about the father thinking proactively, the practical aspects of the scenario (e.g. about the management of his prized camera) and the obvious ways he could have avoided escalation, but it was also about him thinking of Luke's feelings as the contact came to an end. The group members have been able to ally themselves with **both** perspectives, not just the parental viewpoint, which has then helped them relate to their own children's position.

Within non-violent resistance in general, parental efforts to reconcile with their child through relational gestures were still predominantly envisaged as coming after or running parallel to the parents' acts of resistance (Weinblatt & Omer, 2008, p. 82). We actually started to use the relational gestures in a priming way; that is to say before, not just alongside or after, the intervention. We had learnt that, when parents were encouraged to implement the gestures, not only following an incident but at other times, the child learns the parents have been holding them in mind. In our subsequent groups, we have gone on to incorporate some psycho-educational material on how the brain functions when a child is in a state of anxiety, explaining fight/ flight/freeze responses. Additionally, we now consider earlier on in the group process the question that all parents ask, "Why does my child behave like this?", using ideas from Haim Omer on the international non-violent resistance/new authority website (Omer, undated).

Dyadic developmental psychotherapy

Another development that made a profound change in our practice was when, in summer 2012, our service received training from Kim Golding in the dyadic-developmental-psychotherapy approach. On his webpage, Dan Hughes describes the development of this model:

"Daniel A. Hughes, Ph.D has actively worked to develop a model of treatment and parenting for children with problems secondary to abuse, neglect, and multiple placements. This model has evolved over those years, incorporating both his experiences in providing such treatment and in teaching other therapists along with his ongoing reading from attachment and trauma studies in both academic and clinical literature. Dr. Hughes has chosen to call this model of treatment Dyadic Developmental Psychotherapy because it is based on the premise that the development of children and youth is dependent upon and highly influenced by the nature of the parent-child relationship. Such a relationship, especially with regard to the child's attachment security and emotional development, requires ongoing, dyadic (reciprocal) experiences between parent and child. The parent is attuned to the child's subjective experience, makes sense of those experiences, and communicates them back to the child. This is done with playfulness, acceptance, curiosity, and empathy. These interactions are contingent, i.e., when the parent initiates an interaction, the child's response determines the parent's subsequent action based on the the feedback of the child's subjective experience of the first action. In that way, the parent constantly fine-tunes his/her interactions to best fit the needs of the child. The primary context in which such dyadic interchanges occur is one of real and felt safety. Without such actual and perceived safety, the child's neurological, emotional, cognitive, and behavioural functioning is compromised." (www.danielhughes.org)

It was immediately apparent that aspects of the approach fitted very well with non-violent resistance. We went on to test this out in our next group and found the ideas helped us to enhance the child focus within our work with the parents.

Golding and Hughes (2012) explain that the 'attitude' of PACE (playful, accepting, curious, empathic approaches) is "at the heart of helping children with trauma and attachment difficulties as well as being helpful for relationship strengthening generally".

We realised that, through the strategies described above, we were engendering in the parents' **curiosity** about the behaviour. Staying curious as to what may be behind the behaviour means the parent is less likely to feel cross or frustrated. A questioning and wondering approach means they are more likely to remain non-judgemental and therefore manage to de-escalate and help the child to be open to inter-subjective experience. This can then lead to understanding, which increases **acceptance** of the child's internal experience and reasons for behaviour. This also promotes de-escalatory approaches from the parents and fosters the potential for emotional engagement with the child.

The dyadic-developmental-psychotherapy concept of the 'shield against shame' further helped build on the parents' understanding of the potential reasons behind their child's behaviour and rein in the potential blaming and shaming of the announcement, sit-in message campaign and tone down potential punitive responses and help shift the parental focus from the behaviours to what's behind them.

Blame

'It's his fault'

Minimise

'It wasn't so bad'

**Lie**

'I didn't do it'

Rage

'You always blame me'

The shield against shame (after Golding & Hughes, 2012)

The shield image emphasises that, if discipline occurs with rejection, humiliation or anger, the shame can be overwhelming and so increase the behaviours as a defence, inhibit attachment and reduce the likelihood of change. The protective shield then becomes larger and thicker; in effect, the behaviour escalates. As Golding and Hughes crucially emphasise; 'Connection before correction', drawing attention to the importance of providing discipline with **empathy** and support.

Playfulness can be the hardest element for the parents to embrace but it is closely linked to relational gestures, encouraging them again to think about what fits with their child's needs and, in this way, thinking of the emotional rather than chronological age of the child. This can repair and develop the relationship, stressing the availability and responsiveness of the parent and offering the chance to reconnect with memories of more attuned interactions. A playful approach can help de-escalate a situation. We saw the great contribution of playfulness, and 'PACE' in general, to the repair part of the non-violent resistance watchwords '**resist, persist, unite, repair**'. We started to think of it as '**resist, persist, unite, repair, respond, relate**', adding more of an emphasis on the nurturing side as a counterpoint to the resisting side. In fact, the dyadic-developmental-psychotherapy concept of the 'two hands of parenting' (Golding & Hughes, 2012), providing both care and discipline, encapsulates the two discourses incorporated in non-violent resistance; high boundaries with high warmth (not the same as being soft) being the ideal balance of parental presence.

Following the training with Kim Golding, we reflected on the work we carried out with Luke and his parents and saw that, in dyadic-developmental-psychotherapy terms, the parents were in a position of 'blocked care' and unable to attune with Luke. We learned from this, and from other adoptive parents especially, to be much more explicit regarding how early trauma is linked to those functions of the brain leading to the flight, fight, freeze responses, especially at times of high states of arousal. We found this helped parents empathise with their children. If the parents can shift to see their gestures not as a reward or a bribe but

as symbolic of their parental presence and care, i.e. aimed at the child's unmet needs, and take the leap of faith, ultimately the behaviour and relationship with the child will improve. It must be acknowledged, asking parents, who are being hit, spat at and verbally abused, to 'look behind the behaviours' and offer relational gestures to meet unmet need, is a huge ask. One way we worked with this was by addressing the importance of the parents looking after themselves, by introducing wellbeing and mindfulness into the group. The impact was positive, and we found the parents spontaneously started to use some of the breathing techniques with their children as relational gestures.

As we continued to run our groups, we increasingly found many of these dyadic-developmental-psychotherapy concepts were helpful for birth parents also. At first, we were wary that we would be entering more sensitive territory because of the potential here for the parents to feel shame about their past parenting. Indeed, we experienced the need to go carefully and, for some parents, it was an area too difficult to venture into. However, for many parents it did reawaken a lost sense of connection and, at the very least, it provided ideas for relational gestures and promoted de-escalation though lighter and more understanding responses while still taking a stance of firm resistance to the targeted behaviours. One parent had a dramatic turning point when she could suddenly view gestures she was already making in a different light; instead of seeing picking up a wet towel her child had left on the floor and putting it on the radiator to warm as 'acting as a slave' she chose to see it as giving 'a warm hug from Mum'. She took back some control by giving the gestures rather than feeling they were forced from her.

In parallel to our experiences, our team's 'Promoting Attachments' group for foster carers has also incorporated some ideas from non-violent resistance into their dyadic-developmental-psychotherapy-based approach; further illustrating both programmes are open to cross-fertilisation. Our experience from linking the models has resulted in parents being willing to go that little bit further and be even more persistent in their efforts to reconnect or hold out a hand of hope to their children. This was particularly evident in adoptive parents from the last group; they had been struggling with their son's drug use and the ensuing violence he used to extort money from them to buy the drugs. The parents introduced relational gestures and he responded well and they began to see 'their son' again. However, the lure of drugs was too much and, one evening, he severely beat them up, was arrested by the police and they were advised by the police not to allow him home (he was eighteen years old). The dyadic-developmental-psychotherapy element of the group helped them understand what was behind his behaviour and his reliance on drug taking, but the non-violent resistance element helped them recognise they needed to regain their parental presence. The couple continued with relational gestures whilst their son was 'sofa surfing': they transported him to the benefits agency, they met up and provided him with food, took him for help with his drug dependency, and they texted him frequently to show they were thinking of him. Eventually, they made an announcement, raising their parental presence further, and they allowed him to return



Left to right: Margaret Smith, Denise Wilson and Rachael Aylmer at the non-violent resistance conference in 2011 Greenwich

home, against police advice, and are continuing to manage the situation as strong parents. Even in this extreme situation, the (adoptive) parents were able to continue to offer the relational bond and the family home as a secure base for their child. This was an important lesson for us within the current context of the loud 'criminological dialogue' (Condry & Miles, 2013, p. 16) about adolescent-to-parent violence. We feel that maintaining a relational focus within this discourse is not to minimise the behaviour, but to remember also the unmet needs of the child that is adrift.

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Fathers and non-violent resistance

Julia Jude and Veronica Rivera

"Things are better now than they were because I am different. I see things differently."

"I found it terribly hard to watch him hurt his mother across the room, hit us, try to throttle us or throw chairs. It made me very angry, and my response was to physically restrain him by pinning his arms and getting him to the ground until he eventually calmed down from his intense rage. I really hated this. I really, really hated this, and I love my son and did not want any of this confrontation."

Professionals who work with young people and their families often keep fathers in the shadows, especially if they are not in the family home or they show initial reluctance to take part in treatment. This is often done by professionals appearing to lack curiosity about fathers' presence in the lives of the children. They might take the position that it is not for therapists to get involved in that aspect of the family's lives. Our approach takes an inclusive view. If fathers are present in the therapeutic conversations and there are no concerns about having his involvement, then we actively try and encourage participation.

The testimonies at the start of this paper are from the voices of fathers who participated in the Oxleas parenting-groups. As well as drawing on their lived experiences, we explore the wider contextual stories told of fathers and their relationship with therapy.

In May 2013, we ran a parenting group and discovered we had a high number of fathers present. These fathers attended every session. This was unusual in our experience. We were surprised, delighted and curious to explore how this happened, as well as how we might use the knowledge gained to improve the support offered to fathers. We interviewed these fathers to begin to answer these questions. Along the way, we explore some widely accepted ideas of fathers in therapy. When we use the word 'fathers', we refer to men who have taken on the responsibility of participating in bringing up a young person.

Big boys don't cry: Sacred cows, myths, and truths of male view and experiences of therapy

There is still a notion of masculinity that seems to suggest men and therapy don't go together. Addis and Mahalik (2003) suggest fathers have to be dragged to therapy as a result of a crisis in their life. They argue this is associated with negativity towards psychological support, stemming from early childhood and the way boys are conditioned. Good *et al.* (2005) argue men have lost their role in society and have little control over their lives and thus have become destructive both to self and others. They argue what it means to be masculine has changed and continues to change – socially, economically, and in terms of race and ethnicity. This has resulted in men not knowing how to be or what to be. For them to enter therapy, the field needs to demonstrate it understands men's issues.

Jordan *et al.* (2012) conclude that agencies working with men need to include them and their emotional needs. Services need to be more proactive around access and outreach, and may be more engaging if they are not exclusively related to mental health but also social community-service groups. They referred to the stigma attached to the perception of men seeking help and the expectations for males.

Consistent attendance was expressed to be a sign of having a good experience with the services and hearing the testimonies of others improved attendance and outcomes. They suggest clinicians' attitudes are crucial in building rapport and engaging them in treatment.

The situation seems to be somewhat different in America. Research suggests black men are entering therapy. Thorn and Sarata (1998) indicate working class black men and women seek therapeutic support. They argue racism and self-esteem is one of the main reasons for entry into therapy. Boyd-Franklin and Franklin (2000) suggest, *"Raising African-American sons is one of the greatest challenges on the face of the earth. Worry goes with the landscape but if we are to make a difference for our young men we must follow the words of the Ashanti proverb ... 'You must act as if it is impossible to fail'"* (p. 6). The authors describe the importance of love in bringing up black boys and argue the value of fathers cannot be overestimated. The importance in clinicians giving men an active role in the family dynamic, as well as in the attention given to their children's behaviour, can carry a significant change to the way fathers, and stepfathers are often perceived and treated.

What we need to know

The literature suggests that social and cultural constructions of fathers in therapy tend to be negative and emphasise lack of involvement. However, there are other lived, unique, rich local stories, told by fathers. We interviewed six who attended our groups and will go on to carry out a focus group.

During the interviews, the fathers received information about the importance of participation, follow up, and completion. Both interviewers had already met with them during their participation in the programme. What follows are some of the highlights and responses found from two participant fathers (one from Anglo-Saxon and the other from Asian descent).

How did you become involved in the group?

"It was my social worker who involved us in the group, we wish we were offered it before but it wasn't offered. When she called us in we thought, yeah ... we'll go."

"I would give anything a try."

What made you come to the group?

"To get a better relationship with my daughter."

"I was having problems with my son ... and I found that no matter how hard I tried, communication wasn't being made."

What was your initial feeling when presented with the idea of non-violent resistance?

"When it was first presented to me, I didn't want to come; this was not for me."



Veronica Rivera

"When I first heard of it, I wasn't too keen."

What was your initial feeling when arriving to the first group session?

"I didn't want to talk at all. I don't even talk to people at work ... but when I got there yeah, I found it easier."

"Embarrassing; it's embarrassing, and initially you are reluctant."

Do you remember what you were thinking?

"I didn't think of anything bad, I didn't think there was much to talk about, 'cause it's gone on for years ... we just have to get on with it ... but I did get something from it."

"Initially when you came to my house, it was mostly women, so immediately we (men) are taking a step back, and you say hold on a minute this is a women thing, let her deal with it, that was my one issue. However, I'll always look for proof, so if someone says this system works then I would say, 'look, I can't say it does or it doesn't unless I've tried it.'"

What helped you stay and follow up and return?

"It was other people being in the same situation. I was grasping it, it was making sense."

"Meeting people who have similar problems, and when they talk about it and you start to talk about it, it makes things easier. You can say something without feeling embarrassed or someone judging me."

Can you tell me how it was to speak in front of other people who were not your own family about your problem?

"It was a massive step.... yeah it was a massive step. It felt as if everyone's story was the same and that we were all in the same situation. I couldn't speak with someone if you had never experienced it ... it would not be worth speaking to someone because they wouldn't know where I am coming from."

"But I wouldn't have attended if my wife hadn't been there. We both felt that we both had to go ... something had to change 'cause nothing was changing ... we had a bad run through life with my daughter ... we now use what we have learnt ... Things did change; we are really chilled out."

What made you complete the program?

"It worked, I saw results."

"It's what's at the end of the tunnel, isn't it? Why would anybody want to complete anything if you don't see what the results are. You start something; you must see the results at the end of it. Why do something halfway and then say it didn't work? I was enjoying it; it was all right. It was fun."



Julia Jude

Conclusion

This is a research study in progress. What is emerging is that the role of the father is an important one. From the interviews, fathers shared their sense of achievement of actively being involved in their childrens' lives. In some of the literature reviewed, there is an assumption men are simply not interested in talking. The point the fathers made was that is was much more than 'just talking'. Part of the reason was connected to fear, shame and pride; having to talk so openly about the troubles they were having with their children, and their sense of failure. They also told us what kept them coming to the group was the tools they acquired which they could use, test out and give feedback about their experience to the group. Their ambivalence about entering therapy might be more about how fathers are invited to talk. Perhaps we need to know more about what we don't know. What we do know is that the fathers we spoke with have feelings, which are not signs of weakness but signs of being human, which this approach seemed able to access.

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Restoring competence and confidence – non-violent resistance as a response to child-to-parent violence in Ireland

Declan Coogan and Eileen Lauster

In this article, we describe some of the difficulties some parents and therapists can encounter when faced with child-to-parent violence. We hope to show that an adapted non-violent-resistance programme restores confidence and competence to parents who have lived with such violence; the programme also provides therapists with a helpful way to talk with parents about their experiences of violence. Such conversations can lead to an end to the fear and isolation at the heart of the experience. We will also outline an innovative research project involving five countries in the European Union that includes, as its objectives, increasing awareness of child-to-parent violence and exploring participants' responses to a two-day training programme on non-violent resistance. As a way of reflecting on experience and practice, we will also use an anonymised case-example, drawn from the experiences of one of us.

Child-to-parent violence: Helplessness and hopelessness

Kathy and Tom, the parents of 14-year-old Marie, attended an appointment at their local out-patient child and adolescent mental health service in Dublin. She had refused to join them, shouting that there was nothing wrong with her; her parents were "crazy" and "it was all their fault". As they spoke to the therapist, the parents described feelings of hopelessness and helplessness as their 14 year old, over the last few months, had begun to stay out all night, use alcohol and drugs, shout and scream at them and at her younger brother, had broken a door and window and had threatened them with physical violence. They could not understand how Marie, who up until recently had been pleasant, happy, out-going and close to them, could change so much and treat them so badly. They felt there was nothing they could do. They felt at a loss ... and, initially, the therapist felt the same way.

The experience of child-to-parent violence is surrounded with a veil of silence, with embarrassment, shame and fear (Gallagher, 2004; Holt, 2013), making it very difficult for a parent to initiate a conversation about it. It can also be very difficult for a therapist to detect that this may be a reality for family members with whom they are working. One of the reasons it can be difficult for therapists and for families to even begin to think about is

that there are similarities to, but important differences also between, child-to-parent violence and domestic violence (Wilcox, 2012). Such difficulties are not helped by the invisibility of child-to-parent violence in domestic violence official guidance and policy in Ireland and the UK (Coogan, 2011; Condry & Miles, 2013), making it seem as if the problem does not really exist and as if there are no meaningful ways to respond to it. Neither are such difficulties helped by the potentially confusing variety of terms used to describe the problem.

What is child-to-parent violence?

Child-to-parent violence can be defined as an act carried out by a child with the intention to cause physical, psychological, or financial pain or to exert power and control over a parent (Cottrell, 2001; Calvete *et al.*, 2013). We prefer to use the term 'child-to-parent violence' for a number of reasons:

- a. it encompasses a wide range of abusive behaviours, including acts of violence and controlling tactics;
- b. it indicates that it is the parent (or a person acting in the role of a parent, such as a foster carer, for example) who is the target of the abusive behaviour by the child under the age of eighteen years of age;
- c. the term clarifies that it is the child who uses violence to dis-empower the parent/carer.

Therapists working in children and family services in the community may find it difficult to recognise that a child, who may be a survivor of domestic violence and/or abuse at home, can also be responsible for the use of violent and abusive behaviour. Sometimes, diagnostic labels such as attention deficit hyperactivity disorder or attachment disorder may be misunderstood in ways that can obscure the realities of accountability and choice involved in the use of abuse and violence at home by a child. Parents and therapists may also be uncertain about identifying the difference between what could be described as typical challenging behaviour such as a son or daughter shouting, banging doors and name calling and child-to-parent violence. We suggest that one useful way to make that distinction is to consider the power dynamics within families: from this perspective, it is an abuse of power by the child or adolescent through which he or she attempts to dominate, coerce and control others in the family (Tew & Nixon, 2010; Coogan, 2011).

There is evidence to suggest child-to-parent violence can be found across a range of family circumstances and socio-economic backgrounds. Weinblatt & Omar (2008) and Calvete *et al.* (2013) refer to studies in Spain, Canada and the United States that indicate 5% to 13% of parents are physically assaulted by their children, mostly boys and mostly – though not

exclusively – targeted at mothers. As part of the European Union funded Responding to Child-to-Parent Violence Project, we are working with partners to develop a clearer picture about the experiences of the violence and raising awareness about this problem in five European Union countries, including England and Ireland.

What is the Responding to Child to Parent Violence Project?

Led by Paula Wilcox and Robb Cunningham from Brighton University and Michelle Pooley from Brighton and Hove City Council, the Responding to Child to Parent Violence Project runs until January 2015, with an emphasis on integrating intervention and research in responding to child-to-parent violence. It is funded by the European Commission's Daphne III Programme which supports Europe-wide projects that address issues of violence against children, young people and women. The practitioners and researchers involved in the project are in Bulgaria, Spain, Sweden, England and Ireland. We share the common hope of increasing awareness about such violence and of implementing and carrying out research on two intervention programmes – namely Break4Change and the non-violent-resistance programme. The Break4Change programme is a group and multi-media based intervention which involves parents and children in separate and concurrent group-work sessions. It has been developed by the Brighton & Hove City Council and their partners. Contact-details for Break4Change can be found at the end of this article.

In Galway, Ireland, the Responding to Child-to-Parent Violence Project at the National University of Ireland is joined by COPE Galway/ Waterside House, a women's refuge and outreach service in the West of Ireland. Colleagues from COPE Galway/ Waterside House will join us in hosting an international conference at the National University of Ireland Galway on 12-13 June 2014 entitled, *Child-to-Parent Violence: Innovations in Practice, Policy & Research*. Scheduled speakers include Peter Jakob (who developed the non-violent-resistance programme in England) and Eddie Gallagher (who works with families in Australia). Project members from the five different countries will describe their local responses and their research findings and activities. More information about the conference can be found on the website given at the end of this article.

Non-violent-resistance as a response

But the question remains: how best to respond to problems described by parents such as Kathy and Tom in a way that avoids the cul-de-sac of blaming parents but yet offers real promise of a resolution? An empowering and innovative response seemed to be offered by the non-violent-resistance programme (Omer, 2004; Weinblatt & Omer, 2008). There were promising results in Israel from this programme, which assists parents in the development of a new awareness of their own role in de-escalation cycles, of new skills and of a support network in their responses to child-to-parent violence. The programme, adapted in Ireland with the support of Omer, seemed to enable Marie's parents to regain a sense of confidence and competence as parents, while building on the positive aspects of their relationship with their daughter. It also made room in clinical sessions for stories of resilience and strengths, which seemed to be much more useful for the family, rather than focusing on the role of genetic factors or family 'deficits' (McKenna, 2010).

Throughout eight sessions, the parents developed new skills and, with the therapist, explored successes and setbacks in their implementation of the approach at home. Key factors of the programme are described elsewhere in this issue of *Context*. In relation to the work with Kathy and Tom, these included:

- the parents' disclosure about the extent of the problem of violence with a number of significant people whom they also invited to be part of a support network, including a grandmother, who until recently had ceased contact with Marie;
- the parents' development of self management and self calming skills;
- the announcement to the family that violence at home was no longer tolerated;
- parental reconciliation gestures.

On completion of the programme, Kathy and Tom reported their relationship with Marie had hugely improved, they were no longer living in fear of their daughter and she was no longer going missing for long periods.

The non-violent-resistance training programme in Ireland

The positive experiences of the clinical team members and of the families in North Dublin who had used the programme over an 18-month period between 2008 and

the end of 2009, led to an appreciation of the potential that lay within the approach to enhance the safety of children and parents, to end violence and to improve family relationships. Following a presentation outlining the key elements of the programme by Declan at the annual conference of the Irish Association of Social Workers in 2009, some individual practitioners and managers in children and family services suggested the development of a training programme to assist practitioners in responding to the emerging problem of child-to-parent violence. When Declan commenced employment as a social-work educator and researcher at the National University of Ireland in late 2009, this presented an opportunity for the development of such a training course, together with the integration of research and practice development. As part of a PhD research project, the two-day training programme in non-violent resistance was developed, piloted and delivered to practitioners in different voluntary and statutory children and family services in Galway, Ireland.

Researching child-to-parent violence and intervention in Ireland

As part of the five nation Responding to Child-to-Parent Violence Project, the non-violent-resistance training programme was delivered to a multi-disciplinary group of child and family and domestic-violence practitioners in Galway in Ireland and in Brighton in England. At the same time, training on Break4Change was also delivered in Brighton. The training events were also delivered to local authority workers in Amål in Sweden. Eileen joined the project in August 2013, enabling the expansion of the training and research activities. Daphne co-funded non-violent-resistance two-day training, and research on child-to-parent violence is taking place throughout 2013-14 with, for example, probation officers, national family support network members (who work with families with drug and alcohol abuse problems), staff and volunteers of Parentline (a national telephone-support service for parents in Ireland) and domestic-violence refuge practitioners in Northern Ireland. Participants are asked to complete questionnaires that gather data on the effectiveness of the training. All of this information will be disseminated by the

completion of the project. In addition to training events, both of us have delivered papers at conferences.

First impressions of practitioners' experiences

The training events and presentations we have been part of seem to create welcome spaces for practitioners to exchange with each other their experiences of working with child-to-parent violence. For example, when Eileen spoke about non-violent resistance with housing authority social workers in the south east of Ireland, they shared their experiences about drug dealers approaching families for drug debt caused by a son or daughter. They also spoke of child-to-parent violence among minority groups such as Travellers. They report that, much like the experiences of working with domestic violence survivors, it is difficult to start a dialogue within this minority community on the subject of child-to-parent violence. It also seems that the non-violent-resistance approach helps practitioners find useful ways to think and talk with parents about how best to respond to their experiences of child-to-parent violence.

Next steps for the non-violent-resistance programme in Ireland

As we listen to, and take part in, conversations with practitioners, it also strikes us that a distinctive feature of the approach is that it directly addresses the relationship between the parent and child rather than exclusively focusing on working with the child and his or her behaviour. One of the difficulties many practitioners face when working with parents living with such violence is that the child either refuses to accept any responsibility for their behaviour or they refuse to attend or engage in sessions. In Ireland, using the non-violent-resistance approach, we bypass these difficulties by working almost exclusively with parents in a targeted and time-limited way to develop the confidence, skills and support needed to bring an end to the violence at home. Elsewhere in this issue of *Context*, others describe child-focused work where child-to-parent violence takes place in ways that could complement and enhance the non-violent-resistance programme in Ireland.

Since February 2013, the responding to child-to-parent violence project has enabled us to raise awareness about, provide training and discussions in Ireland about child-to-parent violence. We hear

from our partners in Bulgaria, England, Spain and Sweden that this is also true in other parts of Europe. Although a lot has so far been accomplished throughout these five countries, there is still a great deal of work that needs to be done. We look forward to sharing the insights that emerge from the research taking place and to hear about local interventions throughout Europe from key speakers during our conference on child-to-parent violence at National University of Ireland Galway on 12-13 June 2014. It seems to us that the integration of intervention and research and the promotion of the key principles of the non-violent-resistance approach are useful ways to restore the confidence and competence of parents and to assist families to develop more peaceful relationships.

Contact information

The Responding to Child to Parent Violence Project: www.rcpv.eu
The International Conference on Child to Parent Violence: Innovations in Practice, Policy and Research 12-13 June 2014 in Galway Ireland www.cpvireland.ie
Break4Change programme in Brighton & Hove City Council <http://www.safeinthecity.info/getting-help/child-to-parent-violence>

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Non-violent resistance:

A community-group programme for Latin American families

Liz Day and Gilda Flores Aqueveque

There are about 113,000 Latin Americans (refugees and migrants from South America who speak Spanish or Portuguese) living in London (McIlwaine *et al.*, 2011). They come from many different countries. Many Chileans, as well as some Argentinians and Uruguayans, came in the 1970s as political refugees fleeing from the military dictatorships of Pinochet and Bignone. Others, who came before the unskilled work-permit scheme was withdrawn in 1979, included Colombians, Ecuadorians and Bolivians. Latin Americans have a higher rate of employment than the London population as a whole, but are more likely to be employed in low-paying jobs in service industries, even though over a third were employed in professional or management positions back home. Many are isolated through lack of a working knowledge of English and only a fifth of them use mainstream services and resources. The boroughs of Lambeth and Southwark have the highest numbers of Latin American residents.

Their children face significant difficulties in terms of educational achievement. For newly arrived families, there is a lack of familiarity with the new culture, and children often have to take on a carer's role with younger siblings in the family, due to their parents' fragmented work-patterns and antisocial hours (cleaning teams often work through the night while offices are empty). Children find themselves included in adult conversations about the social and financial difficulties faced by the family and may need to act as interpreters for their parents.

Gilda was aware of these issues through her work with Shelter and the Latin American Women's Rights Service. She wanted to create a project that offered support and interventions to parents who were struggling with their children's behaviour. There may be a context of domestic violence or social services involvement, where parents struggled to control their children using some of the physical methods they themselves had been brought up with.

There is no specific service offering family therapy in a therapeutic setting to the Latin American community, or a non-violent resistance workshop, or these services in their own language; Anahi, a counselling service run by the Latin American Women's Rights Service, is for women only. Gilda wanted to provide a secure space where parents could create their own support networks and gain access to other useful organisations, as well as learning non-violent resistance strategies to help with dealing with challenging and/or violent behaviour at home.

Isolation and engagement

Migrant and refugee communities are often isolated and their children grow up in two cultures, which can lead to difficulties in communication when new and old values clash. Parents who bring with them ways of parenting that are unacceptable in the UK are faced with the dilemma of how to bring up their children; they can be left feeling deskilled and hopeless. The concept of a 'new authority' (Omer, 2011) that developed from non-violent resistance can help parents find an alternative way, leaving behind the more traditional view of an authority based on strictly enforced discipline and punishment, and giving parents a sense of clarity and a new understanding of the roles and responsibilities of adults and children.

Latin Americans are known for their preference for meeting in small groups. There is a particular sense of shame about struggling to cope: language difficulties, domestic violence, aggression, abuse, discrimination, anti-social working hours and issues around migration all compound this. Social isolation becomes a natural way of coping with the feelings of shame, and being a member of an ethnic minority group in a large cosmopolitan city makes it easy to avoid services or to disappear. Creating genuine engagement with support services is particularly challenging. Some migrant

communities prefer to use generic services where they are less likely to encounter someone they might know from back home; this can be to do with long standing political differences, fear of retribution or fears about confidentiality. This has not proved to be the case for Latin American families, who have been keen to meet together within a shared cultural setting.

The project was planned and delivered in Spanish by a Latin American family and systemic psychotherapist, a psychologist and by teachers in special education. Given the difficulties of reaching out to migrant communities, the task of recruiting families was a challenge. The team contacted local schools, Latin American charities and organisations. They published articles in local Latin American newspapers, inviting parents to make contact. Gilda was interviewed on the Latin American radio and television stations. A letter outlining the goals of the project was sent to community leaders, churches and local GPs. The London Borough of Southwark Children's Services were offered places for Latin American families whose children were on child-in-need or safeguarding plans. Friends and colleagues were also informed about the project and asked to circulate the information among their contacts.

The programme was designed to work with up to 15 families and offered individual family-support as well as the ten structured-group sessions. The structured sessions followed the format developed by Liz Day and Elisabeth Heismann (2010).

Adapting the group to the Latin American community: rituals, language, music and food

The ten-week group programme was specifically tailored. Some non-violent resistance concepts had no equivalent in Spanish so needed creative re-modelling. The booklet, the parent workbook and the DVD were adapted to their culture and

language. The role-plays were filmed using Latin American actors and local settings. The gestures, the words used and the body language is all Latino!

Early on, the team realised most families were very isolated, their extended family was not in this country and they had no resources to draw on for childcare while the parents were attending the group. The Latin American Women's Rights Service was able to part fund a crèche worker at the centre, who ran activities for the children.

An important aspect of the sessions was to create new meanings for the group by using different exercises. The group always ended with a non-verbal communication exercise that helped parents give feedback about what the session meant for them. These exercises became really popular and were regarded as an enjoyable ritual, which marked the end of each session.

The group had parents from different backgrounds and a variety of Latin American nationalities. Some had direct involvement with children's services, the police or domestic-violence units. There was violent or anti-social behaviour, and some young people were displaying concerning behaviour because of their involvement with drugs, alcohol and/or gangs outside the home.

Half way through the programme, parents began to develop a sense of belonging, empathy and understanding of their difficulties as parents at home, and in their 'new home' as migrants or refugees in this country. Many had exchanged telephone numbers and were meeting at each others' homes to revisit certain aspects of the programme and acting as 'supporters' and friends. As the programme became more familiar and the group gelled, collaborative conversations evolved which deepened the therapeutic impact.

Food and music are very important for Latin Americans, therefore facilitators and parents created a special event that invited the group to bond and to experience a sense of attachment. There was a communal meal where they all brought a typical dish from their country of origin. Parents were also encouraged to bring their close relatives, friends or partners to this social event if they wanted to.

Graduation and testimony

At the end of the programme, there was a more formal graduation event to which participants could bring family, friends

and significant others to witness their achievements. This event was celebrated with music and food and the awarding of certificates. Funders and supporters were invited. During this event, people stood up and spoke about how their lives had changed – this was unplanned and unexpected. A mother, her eyes filled with tears, said that, as a mother, she only did what her parents had done to her. If she had known there was another way of being a parent, she would not have had her first child taken away from her. A boy stood up and said how much nicer his parents were; they didn't argue and no one hit him anymore. The emotion in the room was overwhelmingly positive and full of hope for the future.

Parents reported that they felt:

1. Less hopeless
2. More confident in their parental abilities
3. Increased self-esteem
4. More empowered
5. A sense of belonging
6. Less depressed
7. There was no physical harm
8. There was less shouting
9. They had more control over their anger

Families said their children's schools had noticed changes in behaviour, with the children seeming more settled and having fewer detentions. The families noticed they shouted less at home and talked more. Mothers had started to learn how to stay calm and avoid getting into heated discussions. They still have passionate conversations, but these are no longer abusive and destructive.

Conclusion

For Gilda as a facilitator, it was inspiring to see the positive impact the programme had, the parenting strategies learned and the increase in the parents' ability to communicate with their children and with each other. Parents and facilitators co-created new meanings together in the room, and the group setting intensified the effect. Parents felt more hopeful when they heard another parent telling a story of change and moving forward.

For Liz as a supervisor, who spoke no Spanish and who therefore could only listen to how the language sounded, it was extraordinary to witness the ways in which the facilitators embodied the main principles of non-violent resistance in their voices and their actions. Liz will always remember the mother who spoke to Gilda,

with tears in her eyes, and said, "You have given us back hope".

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Liz Day and Gilda Flores Aqueveque first met when Gilda was a family therapy trainee on placement at Oxleas NHS Foundation Trust, where Liz is a family therapist and one of the authors of the group programme for parents (Day & Heismann, 2010). Gilda is from Chile and Liz has many Chilean friends.



Gilda first learnt about non-violent resistance (Omer, 2004, 2010) during her training at the KCC Foundation. Gilda joined the Oxleas group programme as a facilitator and this gave her the idea of developing a similar resource for the Latin American community in South London. Gilda translated the handbook that she wrote into Spanish.



Liz is principal family therapist at Bexley CAMHS. She is currently completing the professional doctorate in systemic practice at the University of Bedfordshire where her research topic is the non-violent resistance group programme.

From Gandhi to therapy: Some reflections on the meaning of non-violence in systemic practice

Peter Jakob

What is non-violence? Using a case example, I would like to portray nonviolence as a changing social construction, an on-going cultural achievement. Developing an understanding of its underlying principles and practices is central to any therapeutic effort that aims to reduce conflict in relationships.

Non-violence as a positive construct

In general discourse, we will rarely find a positive construct of non-violence – it is simply understood as the absence of violence. Mahatma Gandhi, as with other leaders in the political sphere, was dissatisfied with such a notion. He understood the term ‘ahimsa’ (generally translated into English as ‘non-violence’) to mean an orientation which reaches beyond turning the other cheek, requiring the individual to act in order to reduce or prevent harm – harm to oneself, to a third party, and to the self of the person who is behaving as an aggressor.

Reducing harm to individuals or groups of people can require a pro-active stance. Gandhi criticised inaction in the face of violence, thereby characterising action as a constituent ingredient of non-violence. Sharp (1973) included passive resistance, peaceful resistance, and non-violent direct action in his classification. Following from this understanding, I have developed a definition of non-violence that can underpin therapeutic practice:

Non-violence is the active, purposeful pursuit of peace, encompassing a set of evolving, communally shared beliefs, attitudes and practices, which enable the reduction of harm in human interaction.

Using factor analysis, Kool and Keyes (1990) have identified seven components of what they call the “non-violent personality”:

- Self-control, including understanding and negotiation
- Anti-punitiveness, including compassion and forgiving
- Forbearance including tolerance and judging [*understanding*] the intentions of others
- Equity of justice including equality of adjudicating justice

- Self-defence
- Constructive reform, and
- Affective [*self*] control, including emotional control in the face of irritation. (*italics added*)

Most of these components are relevant to non-violent resistance as therapy. Whilst identified as traits within a personality model, these components can also be seen as states of consciousness, which emerge and grow stronger in the parent who engages in the process of non-violent resistance, as they aim to bring about a more peaceful relationship with their child. A relationship cannot be peaceful when at least one person is continuously inflicting physical and psychological harm on another. From a systemic point of view, we can ask: “*What does peace in human interaction look like?*” Attachment processes may yield some answers: peaceful interaction is connective. Some ingredients of connective interaction are interpersonal attunement, repair of relational rupture, empathy and compassion.

Constructing non-violence in therapy

Fearing verbal abuse and physical violence, Judy, a single parent, no longer woke her son Jake up to go to school in the morning except on occasions when the pressure became too great, and she unsuccessfully tried to get him out of bed, which inevitably led to an angry, aggressive altercation, during which Jake occasionally became violent. Helplessly, she had been leaving him at home to sleep during the day and play ‘World of Warcraft’ all night, worrying about Jake’s well-being and his future, and the threat of her own prosecution, and often angry at the humiliation of having lost her authority as a parent. Jake isolated himself ever further,

and Judy became stuck in a pattern of desperate, angry and anxious attempts to control her son, alternating with helpless withdrawal from him, giving in to his demands and wishes. By the time therapy began, Judy had all but given up asking her son Jake to go to school.

The therapist pointed out that waking a teenage son for school in the morning is what parents do, and encouraged her to raise her presence as a parent by resuming this – albeit in a different manner. Following the therapist’s advice, and learning how to de-escalate whilst resuming her parental authority, Judy was demonstrating – and also strengthening – the non-violent component of constructive reform. Exploring in role-play how she would like to wake Jake up, the therapist noticed Judy’s voice sounded and felt terse.

Therapist: *It feels like there’s an edge to your voice when you wake Jake up?*

Parent: *Yeah.*

Therapist: *What do you feel that’s about?*

Parent: *I don’t know. I guess, I’m already angry, cause, I expect what he’s going to say, but I know I shouldn’t, he hasn’t said anything yet. And I hate it that he makes me feel this way.*

Therapist: *What do you expect he might say?*

Parent: *Well, you know, those horrible things, all the stuff his father used to say to me. It’s like, I’m bracing myself against what’s going to happen, and I’ve got to make him go to school, no matter what.*

The therapist went on to reassure the mother she does not have to make him to go to school – as a matter of fact, it is impossible for her to control Jake and immediately affect his school attendance, so she can let go of attempting to achieve the impossible. He suggested it is more important to restore her authority in her relationship with Jake – albeit in a way in which mother and son

are more likely to re-connect emotionally. Judy practised waking Jake up in a calmer manner, and without insistence – walking away after one or two attempts, but resolved to persist by returning each day.

Forbearance has been defined variously as “*refraining from the enforcement of something*”, as “*patience*”, and as “*endurance in the face of suffering*”. By engaging in the *practice of forbearance*, Judy entered the realm of more peaceful interaction, aiming to reduce the relational rupture that would have ensued from her angry/anxious tone of voice, and the escalation between her and Jake as a result of her insisting on obedience. Judy noticed that letting go of the attempt to control her son brought a strong sense of relief. She fed back to the therapist that her body response changes as she feels relieved from the pressure of having to control her son: when talking in a calmer tone of voice, Judy noticed that the muscles around her shoulders and the back of her neck relax, and her chest feels softer, she breathes more easily and no longer braces herself physically. She also noticed that this different embodied response went hand in hand with an almost immediate shift in her perception of Jake: rather than seeing him as “*the apple that hasn’t fallen far from the tree*”, Judy felt she will be more able to let his verbal abuse “*wash over her*”, whilst inside of herself remaining in touch with the fact that he is still a young boy. She can feel she is becoming more empathic, sensing his anxiety, and more attuned to his moods and feelings – a state of consciousness, which is in keeping with Kool and Keyes’ non-violent factor, *anti-punitiveness including compassion and forgiving*.

All this, however, does not ensure Jake will stop ‘going to war’ against his mother – he is likely to continue seeing her action as an affront, and continue to use violence in order to control her. However, Judy can refuse to re-engage in harmful interactions, by improving her own emotional self-regulation or *affective control*, thereby reducing relational rupture. She increases relational repair by using unconditional gestures of reconciliation, which help to re-connect mother and son. Even though Jake has refused to go to school, Judy plans in the therapy session how she will carry out small acts of kindness at home, to re-assure her son she loves and cares about him. Some of these gestures may even characterise a growing focus on Jake’s unmet needs, and her re-sensitisation to these (see *Non-*

violence and a focus on the child in this issue of *Context*).

This parent has begun to inhabit a very different psychological position. It is characterised by a stance that, in ancient Indian texts, has been called ‘Anasakti’ – a detachment from the attainment of the goals of one’s own action. Whilst one of the goals of the mother’s action remains Jake’s school attendance, she is learning to live with the reality that this will not occur with any immediate effect, that it will ultimately be her son who may become self-motivated to go to school – and that a different, more peaceful relationship between Jake and his mother will contribute to the emergence of this motivation. Growing ‘Anasakti’ brings about a change in emphasis from the ends of a parent’s action to the means of their action: from the end of Jake attending school, to the means by which Judy strives to fulfil that end, and how those means affect both her and his well-being.

Whilst Judy persisted over several days in waking Jake up every morning – in a manner that does not express anger or fear – Jake remained aggressive. On one occasion, Jake pushed her against the wall and punched her. Jake continued to exert harm to his mother and to himself, by not attending school, by being physically violent and emotionally abusive, and thereby damaging their relationship. A non-violent position – as the active pursuit of peace – creates the responsibility for Judy to take action against this harmful behaviour; to remain inactive would mean to tolerate it; she would continue to be harmed by her son, and he would continue to harm himself in the process. It would also become increasingly difficult for her to maintain the stance of ‘Anasakti’, which she has been developing since the conversation about the edge in her voice in the therapy session. This situation requires the mother to become pro-active in her own self-defence. The definition of non-violence I have proposed points to the need for *effective action*: “...*practices which enable the reduction of harm...*”. Were she to face the violent behaviour alone, as she has done in the past, Judy would remain vulnerable, thereby perpetuating the interaction which disconnects her and her son from each other. By engaging the support of a growing network of helpers, Judy can take action against Jake’s violence more powerfully: when she carries out a sit-in in Jake’s room, in order to demonstrate she no longer accepts his violence towards her, he feels

inhibited from acting violently yet again, due to the presence of his mother’s witnesses. Judy can maintain her determined, yet non-aggressive stance, giving Jake the message she no longer accepts his behaviour, which harms her and undermines her efforts for him to return to school. In this way, she moves to a position of strength, which helps prevent her from returning to her more punitive, angry and anxious responses of the past.

As a matter of fact, the strength she derived from this kind of action encouraged Judy to widen her campaign, raising her presence by asking an increasing number of supporters to enter into communication with Jake, persistently encouraging him to return to school, giving him a variety of important messages: “*Your teachers and the other young people welcome you back – you belong to the community of the school; we wish to support you in areas in which you struggle, we believe you will be able to overcome your difficulties, and, importantly, we cannot accept that you are harming yourself and your mother by sleeping in the daytime and playing ‘World of Warcraft’ all night*”. Growing increasingly confident, Judy eventually found the courage to refuse to provide Jake with internet access during the night and during school hours. She invited him to a meeting, at which they negotiated an agreement around use of the internet and his return to school. They communicated more effectively than they had been able to in the past, supported by a family friend who acted as a mediator. In doing this, Judy fulfilled the non-violent characteristic formulated as self-control including understanding and negotiation.

Moving from a pathologising to a re-connective narrative

The positive understanding of non-violence takes therapy in a very different direction. Removed from hypothesising about the root causes of harmful behaviour, the therapeutic conversation becomes centred round the parent’s changing self in action. Returning to the notion I introduced at the beginning of this article – wanting to understand the construct of non-violence as an on-going cultural achievement – we can see that the understanding of non-violence emerges, as its practices evolve. The action methods that parents learn in therapy and use at home are central to how we conceptualise the peaceful relationship, and the non-

violent persons within it. Therapy becomes a process in which therapist and parent plan together, how the parent will become the person he or she wishes to be in relation to their child. To illustrate the shift that takes place when moving from a problem-focused view of aggression to a non-violent perspective, we will return to Jake and Judy, but contextualise their relationship within previous attempts to bring about improvement.

Judy and Jake have had contact with many different professionals over the years. Two different formulations of Jake's violent behaviour, which reflected dominant discourses in child and adolescent mental health services and in the wider society, had a strong, and as Judy told the therapist, often discouraging impact on her sense of self as a mother, and her expectations of improvement. One view saw Jake's violence as a manifestation of 'disorganised attachment', while the other view believed his 'social communication difficulties' (Jake has an autistic-spectrum-disorder diagnosis) to lie at the root of his anger. The latter view led to her feeling Jake's school refusal and aggressive behaviour were chronic, perpetuating her anxious worrying about his future and the prospect of prosecution by the educational welfare officer – and her sense of injustice over the fact that she should be made to feel anxious about school refusal which she could do very little about due to her son's disability. It is unsurprising that her GP diagnosed her with depression, which was treated by anti-depressive medication – reminding me of learned depression, in which a person has internalised the experience that there are no options to bring about a solution to their problems.

However, whilst having a disabling effect on the mother, the 'social communication' formulation alleviated the sense of guilt, which she had felt as a result of the previous 'disorganised attachment' formulation. Judy had felt blamed by what she experienced as a one-sided attribution of her son's angry aggression and school refusal to her parenting, and had reacted to this with even greater anger – towards the professional, and towards Jake himself. In order to alleviate the sense of guilt that thinking about Jake's attachment burdened her with, Judy would shift the blame to a genetic disposition for violence in her son, or at other times believe he had in some way imbibed his aggression when he was still a toddler witnessing the father's violence.

Alon and Omer (2006) have characterised such attribution processes as "psychodemonic narratives". They write, "*The demonic view is a way of experiencing an evolving attitude that begins with doubt, thrives with suspicion, ends with certainty, and aims at decisive militant action*" (p.1). At the core of such a demonic view is the belief in some quintessential negativity within the other person, and it leads to erosion in trust between individuals. Professional hypothesising can promote the development of such psycho-demonic narratives, when an overly-intense focus on the suspected origin of aggressive or otherwise harmful behaviour paints parents and/or young people as quintessentially problematic. For the parent, it amounts to victim blaming, mirroring the victim blaming that takes place in adult domestic violence. When, as professionals, we become overly focused on the question of why a young person behaves aggressively, or what it is about their parent that feeds into their violence, we run the risk of causing harm ourselves. Kool (2008) states:

In at least one way, focus on an individual's disposition will be harmful for the study of nonviolent behaviour. Social psychologists have long argued that we tend to judge others in terms of their personal dispositions, but, for a similar scenario, we tend to blame the situation for our problems. This bias is referred to as the "fundamental attribution error". So, when I see my neighbour become unemployed, I interpret that he is lazy (personal disposition), but when I myself become unemployed, I blame the job market conditions (situation) ... The cognitive processes that fuel such biases in dealing with issues of violence and non-violence have serious implications. For one thing, they create two worlds: us and them. In addition, this dichotomy between "us" and "them" is sustained by continued attributions of this nature and leads to the formation of various types of prejudices (p.196).

The outcome of demonisation is to aggravate and perpetuate the distinction between self and other, them and us: the child becomes "other" to the parent, and the parent becomes "other" to the professional. In the mind of each person, the other, as bearer of an inherent negative essence, becomes more and more of an adversary. In adversarial relationships, we end up attempting to control, and tend to become more punitive. This can be overcome by re-balancing our focus on how parents actively

pursue peace in the relationship with their child. The effect of this is often to energise parents, therapists and supportive networks around the family.

Final thoughts

The shift, from speculating or hypothesising about causational factors, to a positive construct of non-violence, invites parents to engage in re-inventing their own personality. This re-invention can be shared by the professionals around the family, and by the family's wider social environment. A growing support network looks forward in helping family members re-connect and mend their relationships. In this re-connective process, demonisation – and the very construction of "other" – can gradually be overcome. Parent and child can become just that again. Bringing about peace is a fundamentally different process from working out, how the war began.

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Non-violence and a focus on the child: *A UK perspective*

Peter Jakob, Jim Wilson and Mary Newman

Non-violent resistance works predominantly with parents and their supporters. This presents systemic practitioners with a challenge: how to avoid the marginalisation of the many voices of the child, and create space for them in therapeutic conversation. We reflect on meanings of child focus and how it presents in this work.

Jim Wilson: Child focus and non-violent resistance

What is meant by a child focus in systemic practice and therapy?

Working with a child focus is essentially about the practitioner's ability to orientate towards, and engage with, the relational context of a child's life. The practitioner is focused on how to make a useful therapeutic connection with the child **and** all those significant others in its life. It does not mean emphasising the child's presence in the family to the exclusion of all others. Instead, the practitioner attempts to bridge gaps in relationships between the young person and his or her family, friends, teachers and anyone else involved in giving support. To do otherwise is to isolate the young person's context from one's attempt to help.

In one sense, there is nothing exceptional for the systemic practitioner in being child focused. To be focused on the primacy of context and relationship is the first principle of a systemic orientation. However, in practice, the focus can become blurred through a professional discourse that individualises psychological formulations, and the application of methods that objectify and categorise the young person. Hearing the child's 'voice' is often lauded by practitioners from different disciplines, but is too often experienced by children as a silenced, empty word. Children are discussed in terms of their diagnosis or as the 'identified' person, where their identity is limited to a category of deficiency. Yet identity is not one-dimensional; it is created within a matrix of relationships etched from the material of life with others. This suggests that to work with a child focus demands attention to the child's identity as it is shaped by political, social, cultural and familial processes. The child grows within an emotional/cognitive/behavioural context of becoming other than he or she is (after Vygotsky: see for example Holzman, 2009) and this provides the child-focused practitioner with a broad systemic-orientation not restricted to a technical or strategic approach to engage children in therapy, however useful techniques may be.

So where does non-violent resistance fit within a child focus?

From my observations of colleagues and parents applying non-violent resistance, it is clear to me that a child focus is present, either explicitly or implicitly, in the minds and practices of the therapists and parents using this orientation. There is an absence of objectification of the child. Instead, there is an open confirmation of the love and concern that can be hidden behind a parent's feelings of failure, resignation and frustration towards their child, whose violence pushes the parent to become a victim of oppression in their own home.

The Brazilian educationalist, Paulo Freire (1970, 1978), considers that, within the oppressor, there is the one who can also feel oppressed. Likewise, within the oppressed, there exists, in hiding, the oppressor. He was referring here to experiences of subjugation through political oppression, and his assertion corresponds with the political activism of Gandhi and Martin Luther King, whose ideas, in part, inspired the development of non-violent resistance.

The parent who feels oppressed by the young person's violence has the potential to become the oppressor just as the oppressor within the young person has the capacity to feel oppressed. Non-violent resistance strives to alter the child's behaviour by refusing to meet violence with violence. By resisting the young person's provocations, fresh opportunities to reappraise his or her act of oppression upon the parents become possible. He or she experiences a different, less pejorative, and fearful, mode of exchange where new meaning can begin to grow between him or herself and the parent. Repeated over time, the parent and young person create opportunities to broaden their emotional/behavioural and experiential repertoires. This is child-focused practice initiated by the parent. The child experiences a relational shift in response to his or her behaviour, and this step becomes a turning point as the parent's presence and authority becomes reborn and a source of new beginnings. For parents to act against oppression takes courage and determination, whilst holding fast to a foundation of love for their child. Without respect for the child-in-mind, such interventions would lack sympathy for the other and, instead, reduce the practice to a strategic, power-infused dialogue of valour in beating the child into submission. This is not the case in non-violent resistance, because care for the child is central to the orientation.

Questions on non-violent resistance and the meanings of violence

To work with a child focus also raises questions about the child's perspective on being on 'the receiving end' of non-violent practices. What are children's experiences of not being included in the therapy? If it should be that a child's aggressive and violent behaviour is more than a familial habit that has become exaggerated to the point of near destruction, then what other features contribute to aggressive and violent acts? If a child's behaviour has meaning beyond habit formation, what is also being expressed when the fist hits the face? Domestic violence is multi-faceted and has no single origin.

Violence expressed in families can have origins beyond immediate family relational patterns. Political violence enacted on refugees, cultural deprivation, early trauma, and disrupted relationships, may also be present when the fist hits the face. To maintain a child focus also requires a humility that allows for

other ways of construing and therefore intervening in matters of domestic violence, of which child violence towards a family member is one expression. Each violent act will be attached to unique circumstances, narratives and meanings worthy of exploration and attention. Where non-violent resistance makes an important contribution is in tackling violence as a first priority. Once a safe enough context is established and violence is reduced and resisted, then further exploration of therapeutic directions can be made.

Parents as child-focused practitioners

The range of child-focused practices is as wide as a useful therapeutic connection will allow (Wilson 1998, 2005, 2007). The restrictions on offering such a width of practice repertoires are more a matter of therapist training and working contexts than of so-called resistant children. Find the right key and the door will open. The parent or practitioner with a child focus will benefit from a self-critical appraisal of their repertoires and attention to their 'blind spots'. What should be avoided is an easy recourse to approaches that wrongly exclude children from practice because the practitioner is not skilled in dealing directly with their young clients. Thankfully, non-violent methods provide parents with an approach that maintains a child-in-mind orientation, built upon co-operative and communal practices, in which parents find their child-focused repertoires enriched to the benefit of their children.

Mary Newman: Discourse and child focus

Inter-agency dialogues

When non-violent resistance was first introduced into the UK (Jakob, 2006), while the approach was successful, it became clear that conversations with other professionals, unfamiliar with this form of systemic work, had to be carefully considered to enable them to become part of the essential integrated support-network for the family. Some professionals saw the approach as not child-focused, partly because the child did not need to be included in therapy sessions, but also because its main discourse placed the young person as a perpetrator of violence and oppression, at 'war' with their parents, rather than the more familiar 'victim' of poor parenting and/or disadvantage, or of some disorder (Newman & Nolas, 2008). Similarly, in our society there is an emphasis on parents' need to 'control' their children, so parents can feel responsible for their young person's violence towards them. The 'war' discourse of non-violent resistance might be seen to shift the 'blame' from the parents to the child, which could feel very uncomfortable to many child-centred professionals.

However, there is also a discourse of 'family values' within the approach, which includes the parents' unconditional love for their child, even though anger and feelings of helplessness might at times prevent this love being felt by the parents. Weakland and Jordan (1992) describe the benefit of recognising the parental motivation of wanting the best for their child, while at times maybe not knowing how to enable this. Privileging this discourse flows well with the dominant discourses of childhood in our society, preventing dissonance in other professionals while also enabling a child focus.

Due to the dominance of the biomedical discourse within many agencies, it can also be useful at times to incorporate it into our conversations with other professionals, allowing that this approach can help young people with various diagnoses in a clinical setting (Newman *et al.*, in press).

Changing conversations gently in the following areas has also been found to be helpful in engaging professionals and parents in the approach, as they focus on the needs of the young person.

Control versus self-control

Parents are often very relieved to recognise how they might be 'having their buttons pushed' into both types of escalation patterns, either in their attempt to 'control' their child, or when they give in due to their fear of the young person's behaviour and for the sake of a 'quiet life'. Helping parents recognise they can take more control of their own responses, while helping to make their children and adolescents eventually feel more safe, can be very rewarding for a practitioner. Helping parents and professionals step back from the belief that parents 'should' control their child, however, can be more difficult, especially if the child is in the child-protection system. However, it is usually acceptable to professionals and parents alike, when parents are encouraged to work towards refusing to be controlled by their child, in order to provide an environment in which the young person will eventually exert self-control. This meets the need of parents and professionals to feel they are providing an environment which is conducive to the safety and the healthy development of the young person.

Blame versus individual responsibility

While among therapists the idea of discussing responsibility rather than focusing on blame is well recognised, our culture can be very blame oriented. This leads to polarised positions in which 'blame' is the key feature of many discussions when working with the family and the wider system. Parents often 'have tried everything' to attempt to resolve the difficulties, including failed 'solutions' that they might have experienced as young people from their parents, and various parenting strategies advised by friends, relatives, professionals and in the media. However, recognising the parental wish to be responsible parents, and how the approach will enable them to do this more successfully, is a dialogue that can bring parents and agencies together, rather than splitting them with blame. Guiding young people to take more self-responsibility and helping them negotiate their future life more successfully, is also seen by all as caring for the child, and therefore child focused.

Past versus present and future

While blame focuses on the past, the non-violent resistance approach focuses on the present and future. This releases parents from the oppression they can feel from society, and helps them become empowered to change their approaches for helping their child (and the whole family). Guiding conversations away from the past (of parental or the young person's failings) to the future, and centring a parent's wish for the young person to lead a fulfilling life, is likely to meet agreement of all involved, and is certainly focusing on the needs of the child.

Peter Jakob: Facilitating a child focus in non-violent therapy

Caring dialogue

The psychological needs of young people who have experienced abuse or neglect are often very difficult to address. Those who become violent or self-destructive themselves are generally highly dismissive when adults attempt to show care



and compassion. However, even young people who have not experienced abuse, yet act in destructive ways, and whose relationships with adults show the strain of mutual alienation, frequently respond dismissively to care.

Successful caring requires complex interaction: children send distress signals, attentive parents perceive these and carry out acts of care, and the young person feeds back their relief, showing directly or indirectly that they feel emotionally close to the parent. This requires the young person's trust, and skilful, differentiated responsiveness on the part of the adult, who must be able to remain attuned and attentive, read even veiled or distorted signals of distress, and distinguish between needs and wants of the child. Parents persevere and carry out acts of care in often subtle ways. I have called this reciprocal process the *caring dialogue* (Jakob, 2013). In the caring dialogue, parent and child recognise one another, approaching the experience of the *I–Thou relationship* as described by the philosopher Martin Buber, in which there is a genuine encounter between human beings; an opening of each to the other.

The caring dialogue can be fragile. Where it has been disrupted by aggression, constructive resistance will be necessary to reduce destructive behaviour and increase a sense of safety in the child, marked by de-escalation, adult refusal to be controlled by the child, and the raising of parental presence. Omer has conceptualised the increase in child security by experiencing their parents as emotionally self-regulated and containing while strong and fair in their non-acceptance of harmful behaviour, as the *anchoring function of attachment* (Lebowitz & Omer, 2013). This anchoring function is the foundation upon which a child focus can grow.

Reconciliation gestures, a cornerstone of the original non-violent-resistance model, can be used as a powerful instrument for restoring the caring dialogue. By drawing the parents' attention to unmet psychological needs, and helping them plan practical gestures of

reconciliation, which address these child needs, we can stimulate a child focus in the therapeutic conversation, even in the physical absence of the young person. This adaptation of the original non-violent approach has grown out of the work with looked after and adopted children and multi-stressed families; however, in my experience, it enhances *any* therapeutic process involving non-violent methods. Before introducing some of the child-focused methods I have developed, I will outline some constraints to the caring dialogue.

Constraints to parental care

Parents or carers may begin physically to avoid the child in response to aggression and dismissive behaviour, or withdraw their attention. This becomes an automatic response of which parents have little awareness, and leads to a diminution of emotional support. Parents or carers who have been traumatised by violence and abuse in the past can be especially vulnerable to this: as their survival system is activated, sensitivity to child distress becomes eclipsed by their need for self-preservation.

Negative internal representations of one another, in adolescent and parent, reduce empathy (Grace *et al.*, 1993). At times, injury or humiliation leaves parents wanting the child to "*have a taste of his own medicine*", leading to more punitive responses. Retaliatory impulses reduce brain activity, which is usually linked to empathy (Pinker, 2011, p. 557). Antagonistic child-behaviours can reduce the activity of brain areas in the parent that are responsible for sensitivity to child need, for emotional self-regulation, and for providing comfort to the child (Hughes & Baylin, 2012).

Constraints to signalling distress

Aggressive young people live in a subjectively threatening world, experiencing significant others as fundamentally hostile (Barrett *et al.*, 1996). Boys with externalising behaviour have

overactive amygdala-function, and show greater-than-ordinary perception of risk (Vasterling & Brewin, 2005). Symmetrical escalation cements negative representations of the parents or carers in the minds of young people. To appreciate its visceral impact, one can look into the mirror whilst shouting – such is the image of the parent the child carries away. Many parents believe their aggressive child is anxious, but only see short glimpses of the anxiety; distress in young people who are accustomed to becoming aggressive almost instantly ‘flips over’ into anger.

Finally, a particular relational-logic inhibits trust in the adult; a self-referential feedback loop eclipses the experience of unconditional love: by *demanding* and *taking*, the young person denies himself the opportunity to receive; he or she denies the parents or carers the opportunity to *give freely and unconditionally*: “*I get, not because I am in myself deserving, but because I make them give it*”.

Planning need-focused reconciliation gestures

Parents or carers cannot become child focused when feeling angry, humiliated, ashamed or frightened. This requires a position of strength, which the therapist witnesses when a care-giver comes into a therapy session reporting success. When giving an account of how an aggressive incident has been dealt with, body language and demeanour show a strong sense of agency. However, after aggressive incidents, parents are often thrown into confusion, helplessness and despair; such setbacks belong to the territory of dealing with violent or destructive behaviour.

To help parents regain agency, the therapist can invoke previous non-violent action, such as a sit-in, during which the parents were able to respond both calmly and authoritatively to an incident, enabling a more positive sense of self-as-a-parent to emerge. Parents can then plan the next kind of action they wish to undertake, in order to ‘bring a close’ to a more recent incident. It is important parents and therapist expect this to actually be carried out, in order for parents to acquire a position of strength, from which they are then able to take the next step – planning a gesture of reconciliation which will address unmet need in the child.

This gesture should be carried out some time after the non-violent action. Jim Wilson’s child-focused practice (2005) utilises a child’s competence, creating therapeutic space for children to imagine solutions to their problems. This has inspired a number of methods I use to help *parents* re-sensitise themselves to their child’s needs while they plan a reconciliation gesture. Careful, child-focused planning of reconciliation gestures can improve attunement, attention to the child, empathy and supportive behaviour. These methods invite parents to imagine scenarios in which they and their child are competently able to engage in a caring dialogue – exceptions to the problem of a ruptured relationship. Two of these methods are briefly introduced here: *interviewing the parent’s internalised child-in-need*, and the *caring conversation*.

Interviewing the parent’s internalised child-in-need

This is an adaptation of the internalised other interview (Tomm, et al., 1998). E.g., a father will speak with the voice of his daughter. Instead of role-playing her outward behaviour, he is asked to ‘reach behind her anger’, and draw on his felt sense of her distress. The therapist ‘interviews the daughter in the father’, and elicits ‘her’ account of her needs. At the end of this conversation, the internalised ‘daughter’ is asked, what sort of reconciliation gestures

the father could use in order to show he empathises, appreciates ‘her’ needs, and is ready to address them. Parents are often surprised by their ability to empathise with their child – and begin to reconnect with this internal resource.

Following the internalised child-in-need interview, parents actually deliver these gestures. It is important to stress that the child may act in dismissive and rejecting ways. This can even be seen as a unique opportunity: by persevering in the face of rejection and dismissiveness, the parent shows the loving care is unconditional, and does not expect the child to reciprocate.

The caring conversation

The parent is invited to imagine a conversation, in which the child confides in them:

OK, can you imagine Fred coming home from school, upset and angry; but this time, he just goes to his room, he doesn’t shout at anyone or kick a chair over. So, after a few minutes, you quietly walk up the stairs, maybe carrying a cup of tea for him. Can you see this? You open the door a little bit, what do you see? ... OK, so you see him sitting on his bed, with his face in his hands. So you walk in and put down the cup of tea next to him, and sit down quietly. You wait a little while; gently, you say, “Bad day at school, huh?” You wait quietly. Fred shakes his head, and starts talking. Can you see this? So, what do you hear Fred telling you?

Following this imaginary scenario in which the parent has regained caring presence and the child is able to signal distress, a gesture is planned to address the child’s unmet need – in the case above, a gesture indicating the parent ‘gets it’ and is prepared to offer support in dealing with the recurring distressing-experiences at school. Again, parents are encouraged to persevere in carrying out this and similar gestures in order to maintain a stance of unconditional love and support.

Therapeutic network-meetings

This modality can help overcome divisions between parents and professionals who have been seeing a child individually, by joining both sides in working together on a child-focused basis. For example, the child psychotherapist is invited to a meeting with the parents, which is facilitated by the non-violent-resistance practitioner. Having negotiated with the young person what information can be imparted in this meeting, the child psychotherapist gives an account of distress and unmet needs which lie behind the child’s aggression. The parents and the other professional are then encouraged by the practitioner to develop a reconciliation gesture together, which can address the unmet need in the young person. Individual child-therapists have fed back to me that looking *behind* the veil of anger has focused their own therapeutic practice differently, making them more child focused in their own sessions. Parent and child therapist often experience a shift in their perception of one another: a therapist, who may have attributed the child’s problems to the parent, can witness the parents’ positive intentions for the child; the parents who may have felt blamed by the therapist, or excluded from his relationship with their child, can begin appreciating his cooperation and support as a surrogate voice of their child’s distress.

What is the effect of utilising reconciliation gestures for a child focus in the non-violent process?

Starting from the assumption that there may, at times, be meaning behind the anger and aggression that does not easily meet



Peter Jakob



Jim Wilson



Mary Newman

the eye (but not stipulating that distress 'underlies' the violence), utilising reconciliation gestures helps parents re-align their attention to child needs. By imagining a preferred future in which the caring dialogue has re-emerged, they not only come to feel more attuned to and empathic with their child, but also become able to access their own internal resources for addressing the young person's unmet needs. In the process, parents feel further empowered – by their ability to care, even in the face of being dismissed – and more confident, whilst eventually, the young person can realise that their own voice of distress is being heard, however faint its utterance.

Conclusions

A child focus creates space for the unheard voice of distress in the child. The family-values discourse within non-violent-resistance therapy enables us to work in a child-focused way, making the approach more acceptable for systemic practitioners in the UK. A position of strength enables parents to 'anchor' the child and move towards re-establishing the caring dialogue. Several methods have been developed which support parents or carers in re-actualising their empathy, by planning and carrying out unconditional gestures of reconciliation that address the child's unmet need. This child focus in the therapeutic conversation can generalise into the everyday life of the family, powerfully promoting the re-connection between parent and child through the re-emergence of the caring dialogue.

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Mary is a psychotherapist and child-focused systemic practitioner who has led teams within East Kent CAMHS focused on working with parents and families to help the referred child. Mary now works in various settings privately, including offering training, supervision and working directly with individuals, parents, families and foster families. Jim Wilson is a family therapist working part-time with Greenwich CAMHS. He established the Centre for Child Focused Practice (now Centre for Child Studies) at The Institute of Family Therapy in 2001. He presents his work nationally and internationally and is a founding member of the Open Network for Dialogical Practices. He is author of *Child Focused Practice* (Karnac, 1998) and *The Performance of Practice* (Karnac, 2007).

Details of Peter Jakob appear at the end of the previous article.

Examining the evidence for the non-violent resistance approach as an effective treatment for adolescents with conduct disorder

Barbara Gieniusz

The American Psychiatric Association (1994) defines 'conduct disorder' as a pattern of repeated and persistent misbehaviour. Symptoms include: aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules. It is currently the most common reason for children to present to mental health services in the UK (The Office of National Statistics, 2005).

The results of the studies I have reviewed on the use of the non-violent resistance approach with this population are promising regarding short-term reductions in aggressive behaviour, particularly considering that the intervention is relatively brief. Other potential benefits found were: reduced parental helplessness, lower levels of parental depression, increased social support and achievement of treatment goals. Published data is limited and most papers are either not available in English, not published, or describe treatment in the Tel Aviv centre where the approach was initially developed. More rigorous research is needed, especially using more objective measures and also of long-term follow-ups. Little is known about young people's experience of the approach or its effectiveness with different presenting problems such as an unemotional, callous-type of conduct disorder. Since the approach can be applied as a parenting programme, it has potential to become an inexpensive and effective treatment for aggressive and antisocial adolescents while supporting positive relationships with their families.

Parenting programmes were found to be the most effective for conduct disorder in children below twelve but effectiveness decreases with age (Patterson *et al.*, 1993). This leaves a gap for adolescents. This article looks at some evidence of the effectiveness of the approach with the aggressive behaviour of young people, particularly adolescents aged 12-19.

I searched databases for articles related to 'non-violent resistance' and cross-referenced them with specialists using the approach. I found a total of four papers with clinical data related to conduct disorder. Two of the papers included quantitative data. One of the papers was published in German (Ollefs *et al.*, 2009), but an abstract and a conference presentation based on the research were available in English (Ollefs, 2011). In addition to the database search, one unpublished paper, based on a group run in the UK, was given to me by Mary Newman (Newman *et al.*, 2013).

The table in the Appendix summarises the findings and design of these three studies. Specific points related to each study are presented below.

Discussion of the results of these studies

The reviewed studies show improvement in behaviour typical for conduct disorder in adolescents after a non-violent-resistance parenting programme. Some evidence

is not available in English for a full review. Weinblatt and Omer's study (2008) showed that even brief treatment can bring significant results that are maintained one month after completion. All studies show the approach can be effective in improving parental wellbeing. The emphasis on parental response rather than controlling child behaviour, as well as positive values that parents want to relate to, is an important aspect distinguishing it from other approaches (Omer, 2004). Equal effectiveness of the method for adolescents is particularly encouraging (Weinblatt & Omer, 2008). The study by Ollefs *et al.* (2009) showed that, in adolescence, non-violent resistance can be more efficient than another well-established parenting programme. This is aligned with results of other studies showing low improvement in externalised behaviour when using parenting programmes with parents of children over 10 (Scott, 1998). This suggests the way the approach brings changes in families with serious behavioural problems is different to techniques used by other programmes.

Although the study by Newman *et al.* (2013) did not use control groups, it evaluated the approach's acceptance in the UK and showed potential for significant improvement of adolescents on general clinical-presentation. Young people with externalising behaviour have a poor prediction for improvement without any intervention (Offord *et al.*, 1992). Therefore, it is likely that improvement in the UK study was due to the intervention.

Perhaps the results of the Weinblatt and Omer (2008) study in just five weeks were related to adherence to the whole range of non-violent resistance techniques. Ollefs (2011) shows that, in a trial conducted in Germany, more 'intrusive' interventions were not taken up much (e.g. only 2% use of sit-ins). In contrast, Omer (2001) describes sit-ins as an important tool to reduce problem behaviours and that, in 40 families he worked with, 32 tried this technique and found it effective. This raises a question related to the cultural adaptation of therapy, especially in countries that hold individualist values such as a need for privacy for the child.

The Newman and Nolas (2008) discourse analysis suggests that some mental health professionals in the UK might be resistant to using the approach as it is seen as not being child-centred. Descriptions of the approach in the UK seem to emphasise reconciliation gestures and family values more than those in Israel (Jakob, 2011; Newman & Nolas, 2008).

Research implications

More research is needed, especially outside of the centre of development of this theory in Israel, to confirm the effectiveness of the approach in different contexts.

There is very scarce evidence of long-term effectiveness and follow-up is needed to see if benefits are sustained. The

Non-violent resistance approach as treatment for adolescents with conduct disorder

evidence base requires more rigorous research, using control groups or parallel groups with more objective measures than parents' self reports. Questions regarding efficient treatment need to be answered; for example, what the optimal length of the programme should be to ensure sustained results. Other questions that would be of interest to investigate could be whether the methods are efficient in cases of co-morbidity with neuro-developmental disorders such as autistic spectrum disorders, or whether the approach is acceptable and efficient with people with a learning disability. Is it successful with the callous-unemotional subgroup of conduct disorder that was suggested as being a distinct subgroup with more severe behavioural disturbance and changes in the brain (Scheepers *et al.*, 2011)?

Young people from subclinical populations of conduct problems were included in studies; hence, it is not clear if it is equally effective in those meeting the criteria of conduct disorder. More control over diagnostic criteria is needed.

Clinical implications

Research by Lavi-Levavi (2010) suggests young people presenting with problem behaviour see treatment differently compared to their parents. Better understanding of young people's perception when they are on the receiving end of non-violent resistance can be useful in identifying with whom the

approach is most beneficial. Since conduct disorder has a high co-morbidity of mental health problems, the question remains, how well those can be addressed by the approach. Based on the limitations of current research and the need for cultural adaptations, it is important to monitor the effects of this therapeutic approach to contribute to a more robust evidence-base. We are yet to find out more about clients for whom non-violent resistance is not suitable. Since it has a strong philosophical underpinning (i.e. the non-violent resistance movement), perhaps acceptability of this way of thinking by parents and clinicians can be a good indication of whether it is worth being applied to work with a child.

Conclusions

Early results of research on non-violent resistance programmes are encouraging, but not conclusive, about long-term effectiveness in reducing aggressive behaviour in conduct disorder. Success of the treatment in the short term with young people, regardless of age, is particularly encouraging and gives hope for families with adolescents with conduct problems, as other parenting programmes had very limited benefits with age groups over 10 (Scott, 1998). Newman *et al.* (2013) raise the economic issue of the programmes; compared to resource-intensive multi-systemic therapy, this may be an effective yet less expensive option

Summary of the research findings

Study	No of families	Parallel group	Drop-out rates	No of sessions	Follow up	Measures	Significant results
Weinblatt and Omer (2008)	41	Waiting list	1 family from treatment, 3 at follow-up	5 weekly sessions and phone contact twice a week	1 month	<ul style="list-style-type: none"> • Parental helplessness • Social Support Questionnaire • Mental Health Inventory • Child Behaviour Checklist • Parental Self-efficacy • Parental authority 	<ul style="list-style-type: none"> • Lower helplessness in mothers • Better social support in mothers • Less aggressive behaviour and less externalising in children • Reduced permissiveness in both parents
Ollefs, Von Shielpe, Omer & Kriz (2009)	59	'Triple P' and waiting list	Not given	10 weekly session and telephone support	No	<ul style="list-style-type: none"> • Parental presence • Assessment of child behaviour • Beck Depression Inventory • Educational Measure 	<ul style="list-style-type: none"> • Better parental presence • Lower parental helplessness and depression • Improved external problem behaviour
Newman, Fagan & Webb (2013)	44	None	5 families declined, 13 dropped out	12 weekly sessions and telephone support	No	<ul style="list-style-type: none"> • Strengths and Difficulties Questionnaire • Goal-based Measure • Children's Global Assessment Scale 	<ul style="list-style-type: none"> • Lower difficulties and impact score • Improvement in parental goals • Better general functioning of the child

for the NHS. This may need to be considered, particularly since aggression amongst young people presenting to mental health services is a growing problem in the UK (The Office of National Statistics, 2005). Therefore, inexpensive and accessible treatment is needed to help families struggling with this problem. At the moment, the evidence is not sufficient to claim it is effective in work with conduct disorder and, in particular, with children presenting with other co-morbid disorders, and in our cultural context. More research, including current studies from different countries, might provide more reliable answers in the near future regarding applicability and the effectiveness of the approach.

Key points

- Studies show improvement in behaviour typical for conduct disorder in adolescents after a non-violent resistance parenting programme
- Equal effectiveness of the method for adolescents compared to younger children is encouraging
- Adherence to the whole range of non-violent resistance techniques suggests better results
- Positive results can be achieved through short-term interventions
- More 'intrusive' techniques may be less culturally acceptable in countries outside Israel
- Further research is needed to measure long-term effects
- Further research is needed using control groups and evaluating the approach to different client groups and in different cultures

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Lebowitz, E.R. & Omer, H. (2013)

Treating Childhood and Adolescent Anxiety: A Guide for Caregivers.

Hoboken, NJ: Wiley.

Reviewed by Graham Campbell

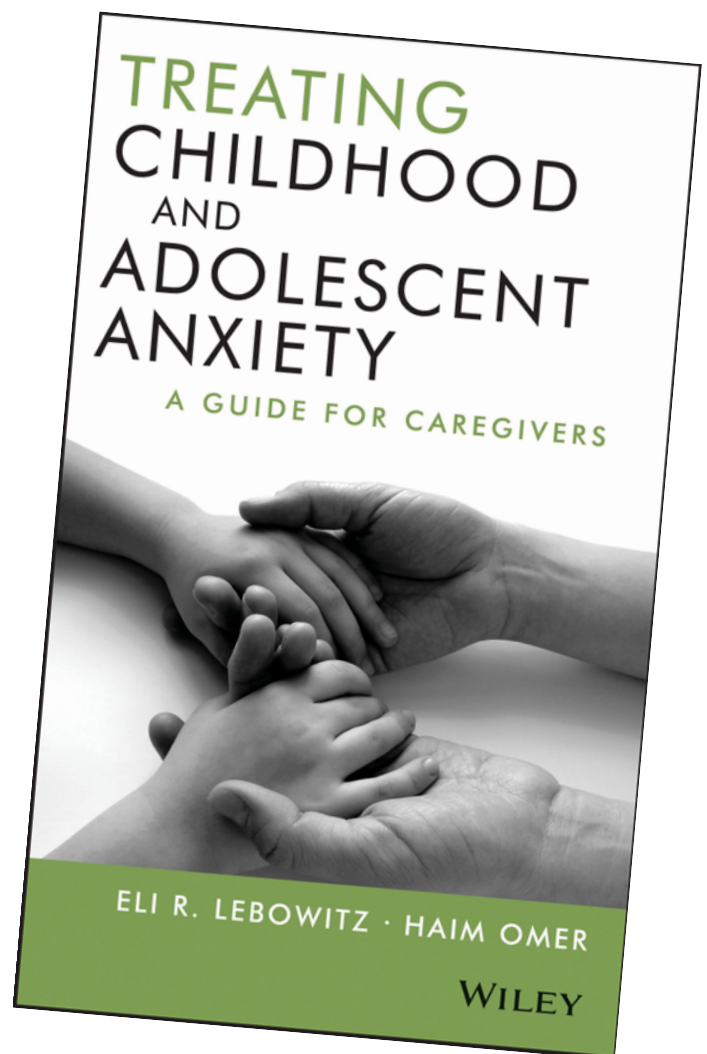
On starting work in a child and adolescent mental health service, I was struck by the various barriers that can prevent young people engaging with treatment: there could be age, cognitive ability or the severity of the problems. Where young people experience anxiety, some might easily engage in the typical treatment of cognitive behavioural therapy. However, some are harder to engage or motivate and services can be left working with parents. Instead of this being second best, work with parents (and 'caregivers') can usefully examine how they inadvertently 'accommodate' or acquiesce to children's anxious thoughts or behaviours. This pattern leaves many feeling helpless and their perceived solutions only serve to reinforce, exacerbate or sustain the original problems.

Treating Childhood and Adolescent Anxiety: A Guide for Caregivers is an essential text for anyone working in this field as well as a well-structured guide for parents of anxious children. The language and content is concise, highly relevant and easily accessible.

The book espouses working with parents using a structured, systemised approach, which empowers them with practical tools and advice. The authors ask parents to reframe their role from protective to supportive, introducing the idea of unilateral parental action to take back control of situations where they feel they have little. In so doing, they step away from accommodating behaviours and leave young people in a position where remaining the same becomes much harder.

This book has fundamentally shifted core elements of my practice and philosophy to enable me to better meet the needs of the children and families I work with, building a family's capacity to manage anxious behaviours and support children to manage their anxious thoughts. I have used the metaphor of parents becoming an anchor to steady the child through their attempts to pull them in different directions. Several parents have responded well to this and have understood it in ways that has enabled them to try a different approach. Thoroughly recommended.

Graham Campbell is a social worker in CAMHS, Portsmouth.



Lebowitz, E.R. & Omer, H. (2013) *Treating Childhood and Adolescent Anxiety: A Guide for Caregivers*. Hoboken, NJ: Wiley.

Holt, A. (2012) *Adolescent-to-parent Abuse: Current Understandings in Research, Policy and Practice.*

Bristol: The Policy Press.

Reviewed by Sue White

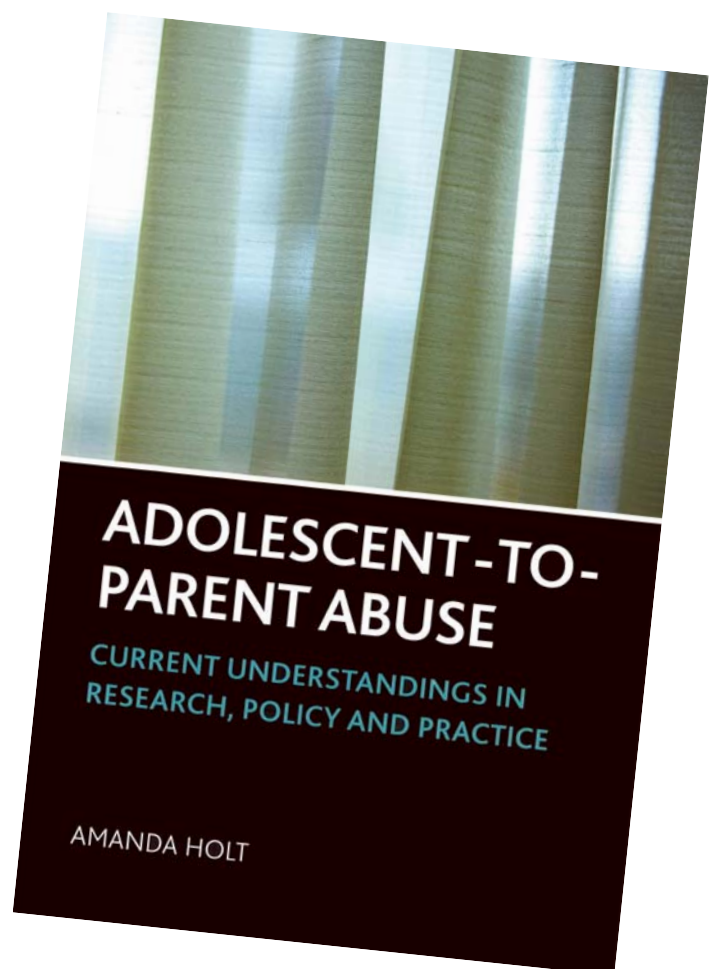
This book offers an excellent introduction to adolescent-to-parent abuse. It helps the reader gain a good understanding of the complexity of defining the problem and the current limitations in addressing this problem. As well as the difficulty in definitions (is it right to call this abuse, where the perpetrator may be so young?), Holt looks at some of the reasons the abuse may develop from personal, cultural and structural perspectives. As this problem has not, historically, been recognised, there is no strong research-base available to help support parents or practitioners, and this is reflected in the limitations to the current responses of frontline services. She makes a strong case that further research is necessary.

The book is easy to dip in and out of and is written in an accessible way. I found her use of personal anecdotes gave a 'real life' perspective and brought the subject alive. However, I would have enjoyed reading more detailed case-studies about the interventions that made a difference to families.

In places throughout the book, Holt speaks about the recent changes in the social status of 'parenthood', 'childhood' and 'adolescence', disempowering parents by challenging the traditional notation that the 'parent knows best'. While this way of thinking may appear to undermine parental authority, I would like to have read more about the wider cultural perspective that considers parents have an innate ability to raise their children in contrast to the professionalisation of parenthood. While all parents may be trying their best, not all have the necessary skills available to them. Without questioning traditional hierarchical systems within families, power discrepancies can lead to other forms of abuse and I feel a devaluing of the skills required to raise children.

Reading this book, I found myself questioning my past and current practice and starting conversations with others about theirs. This is currently a new and contentious issue that challenges the way we as practitioners respond and raises questions about power in relationships.

I would like to find out more about how Holt has created and used the 'adolescent-to-parent abuse initial-assessment' tool to work with parents who have experienced such abuse. While the



book touches on interventions that are currently available to families, I feel I need to read further to find out how these will directly influence and improve my own practice. Overall, this book provides a good starting point and I am left feeling I would like to know more.

Sue White is a social worker at CAMHS looked after children team, Portsmouth.

Adolescent to parent violence conference – a review

Monday 23rd September 2013, St Hilda's College, University of Oxford

Midori Lumsden

A major difficulty when researching adolescent-to-parent violence is the problem is not officially recognised in law. At present, incidents of domestic violence involving a child less than 16 years old lack an official definition. It is therefore rarely acknowledged and impossible to calculate prevalence accurately from legal figures. Researchers, Rachel Condry and Caroline Miles, defined it as *"Physical violence, threats of violence and criminal damage towards parents/carers by their adolescent children (aged 13-19 years)"*. However, this also excludes younger children who may present with aggression in some form. Clearer recognition of this as an offence would help measure prevalence, rather than to consider it as a sub-category of domestic violence with blurry age-boundaries.

Research

Rachel and Caroline provided accounts from parents and young people of their experiences. While contextual factors were considered, it was emphasised these were not to be seen as predictors. The accounts highlighted a context of difficulties with school, arguments at home, controlling behaviours from the young person, past experiences of abuse, lack of support and worries around reporting incidents to the police. Although generalisations should be avoided, it is important not to ignore such potential indicators when the research has shown trends in data; 77% of parent victims were female, 87% of perpetrators were male, families often had a history of domestic violence/sexual abuse, substance abuse, learning difficulties and mental health problems. Rather than viewing these as predictors, it would be helpful to note these as warning signs for services working with families.

Youth justice

Youth-justice responses in the UK can be inconsistent. Accounts were provided of parents who had called the police, despite anxiety about their child having a criminal record. However, they later saw this as 'backfiring' when police took no action and the abusive child was returned home with no safety plan and no apparent reprimand. They felt this response confirmed to the child that their behaviour is acceptable and they can continue to 'get away with it'. It was felt by the justice panel represented at the conference that a united and coordinated response is required at national level. Awareness needs to be raised of this problem so it is more widely recognised and perceptions can be challenged. Parents need to be aware of how police officers may respond to their children so they can maintain a balance of power in the relationship.

Mental health services

Once a family has become known to services, further difficulties present themselves in engaging and offering appropriate interventions. Young people's accounts suggested that referrals to child and adolescent mental health could be futile. They described needing time and space to develop meaningful relationships with services and this was rarely offered. As a CAMHS professional, it was difficult to see where services could create an innovative approach in a context of staff pressures and time constraints. However, the conference concluded with a panel of inspiring individuals and groups who demonstrated that, with time, experience, expertise and enterprise, it was possible to engage young people and start to unpick the complex presentations. All the practitioners suggested that, with a

non-judgemental approach, they could see past the behaviour and through to emotional issues that could then be addressed in depth. This poignant quote came from a 16-year-old girl who suggested, *"There's always something behind everyone"*.

The child's voice

As a relative newcomer to family therapy, I have found the goal of the parent is often at the focus of the work; this may be due to the young person not engaging, or simply because they do not see the need to change. Innovative approaches shared at the conference included Break 4 Change, PAARS, Step-up, Alternative Restoratives and Respect. These propose that it is vital to engage a young person as well as parents in treatment in order for them to truly express their thoughts and feelings. This is something that could be implemented early in family therapy. By giving both parties access to support, this reinforces their joint responsibilities in implementing change.

With services under increasing pressure to demonstrate results, it will be useful to examine the long-term outcomes of these new initiatives. Examining crime figures, once definitions are established, will reveal the extent of the issue and hopefully highlight it to the justice system and children's services. However, by using qualitative methods to represent the experiences of parents and adolescents Rachel and Caroline presented a more in-depth picture. I feel this rich data gives a far clearer picture than figures and percentages. It deserves a wider audience to raise greater awareness of these issues.

Midori Lumsden is an assistant psychologist at Solent NHS Trust