# Re-connecting Parents and Young People with Serious Behaviour Problems – Child-Focused Practice and Reconciliation Work in Non Violent Resistance Therapy

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Non Violent Resistance (NVR) is a multi-modal systemic, community-based form of intervention for serious behaviour problems in young people. The vulnerabilities of young people with conduct problems are largely obscured by their aggressive behaviour. Aggression also leads to alienation between them and their parents, carers, teachers, and other adults. This alienation further inhibits the recognition of young people's distress by significant others. Following on from an introduction to the theoretical background and therapeutic methodology of the NVR approach, this article examines the need for a child focus in parents' or carers' nonviolent resistance to violent and destructive behaviour; it further outlines some therapeutic possibilities that are inherent in NVR reconciliation work, when reconciliation gestures are used to raise the awareness of young people's unmet needs.

**Keywords:** Adolescent; behaviour problems; child focus; Non Violent Resistance; reconciliation; Systemic Therapy

# Non Violent Resistance and Reconciliation: A Coherent Systemic Approach to Strengthening Relationships

The first part of this article sets out to demonstrate the coherence between resistance of problem behaviour in young people, and the improvement of parent-child relationships by virtue of reconciliatory efforts on the part of adults. It is this emphasis on reconciliation which forms the background to the child focus in NVR, which has been developed by the author in recent years.

A young person's habitually defiant and aggressive behaviour towards significant others generally has a coercive effect (Patterson, 1982). Non Violent Resistance therapy (NVR) was developed by Omer and his team at the University of Tel Aviv (Omer, 2004/1, 2001), in order to support parents and other carers develop effective ways of resisting such coercion. The adults' resistance aims to ameliorate the conduct problems of the child, improve family relationships and help overcome parental helplessness. Widely used in Israel, Germany and a number of other European countries, NVR has more recently been introduced to the UK (Jakob, 2006). The approach draws from various traditions of Family Therapy, and applies the philosophy and methods of socio-political nonviolent resistance to resisting violence within the family and community. More recently, applications of NVR have been developed for work in a variety of different settings such as residential care (Körner and Uschold-Meier, 2007), foster care (Jakob and van Holen, 2011), and for different problem areas, such as obesity in children (Eberding and Lemme, 2007), anxiety disorders and self-isolation (Omer, 2004/2)

Whilst there is considerable research implicating a temperamental disposition in the development of aggressive behaviour patterns in children and young people (e.g. Bates *et al.*, 1998), Omer discusses a lack of physical and systemic presence, based on a wide array of studies into child aggression, as key factors in child violence (Omer, 2004/3). NVR helps

raise adult presence and resist the young person's coercion by applying Mahatma Gandhi's and Martin Luther King's principles of socio-political non-violent resistance (Gandhi, 2004; Kurlansky, 2006) to the family environment, school and community.

## An environment in which to practice control

Patterson (above) found that parents and their children get locked into vicious cycles, each attempting to achieve control over the other. Young people and their parents use language associated with control or obedience: "They can't *make me* do anything"; "I *have to* give him money when he threatens me"; "She gives me *no choice*". Locked in a 'logic of control', i.e. "I need to control, in order to stop being controlled / if I'm not controlling, then I am controlled), parents often oscillate back and forth between *symmetrical* and *complementary escalation*. When parents insist on attempting to re-establish control over their child, a pattern of *symmetrical escalation* (Watzlawick *et al*., 1967) ensues, in which each reciprocal move by parent or child to get the upper hand raises the emotional intensity of the interaction. The very high levels of psycho-physiological arousal in the family which result from this pattern evoke mutually reinforcing anger and anxiety. Child and parent show little self-control, whilst developing an intense cognitive focus on the control of one another. Family members develop an intense cognitive focus on control of the other. However, once the emotional arousal, threat or actual violence reach critical levels, parents tend to relinquish their attempt to assert their authority. Feeling anxious and helpless, or embarrassed, ashamed or concerned about risk, parents are likely to start giving in to the controlling behaviour. In this manner, symmetrical escalation is followed by a cycle of asymmetrical *complementary escalation*, during which the adults yield their authority (Patterson *et al*., 1984). More and more of the young person's demands are met, as the parents find themselves acquiescing in the face of their own anxiety, shame, or sense of guilt, emotions which in turn are triggered by their

child's threatening, embarrassing or blaming behaviour. As young people become more effective at exerting control and more violent, and a greater sense of helplessness grows in parents, teachers or carers, these significant adults are likely to show signs of traumatisation, such as symptoms of post-traumatic stress or depression.

## Parental (caregiver) presence

Key to NVR is an understanding of the concept of parental (or adult) presence. While we tend to have an intuitive grasp of personal presence, it can be difficult to describe parental presence in the context of family interaction. Parental presence is in part identified by the determination and ability not to be 'pushed aside', to occupy the parental and personal 'space' in the family, which is necessary so that all children are sufficiently supported and contained in order to thrive. Parental presence can e.g. be established by the parents' physical presence *in a place and at a time of their own choosing,* their perception of and attention to child behaviour and child needs, their use of this physical presence to distribute resources fairly between family members, to guide on appropriate, constructive and safe behaviour, to provide emotional comfort and other forms of support and care, and to mediate and reduce tension and conflict. Research findings indicate that supervision and monitoring of children and young people are the most effective care responses when it comes to reducing risk-taking or dangerous behaviour (Smetana, 2008). In order to supervise effectively, parents need to feel confident about their ability and entitlement to do so. They may believe their effort is futile, when they have found themselves unable to make the young person comply with their instructions. However, concerned and persistent parental watchfulness *alone* have a positive influence on the parent-child relationship, not parental responses aimed at controlling the child. This aspect of parental presence has therefore been described as 'watchful' or 'vigilant care' (Omer, 2011/1).

From an attachment perspective, children require a reliable relationship with a person, whom they can experience as strong and wise (e.g. Bowlby 1982). Omer and von Schlippe (2011) argue, that an internalised sense of security in part grows from experiencing and developing a positive expectation of 'strong' parental authority. Rather than assuming that a child's internal working model of relationship is irrefutably formed during the early stages of development, they posit that changes to parent-child interaction in the here and now can be effective in changing a child's representations of self and parent. Omer (2011/2) has described the 'anchoring function' of attachment as a restrictive, and thus protective quality of parental care – by restricting the child when behaving in aggressive or dangerous ways, the parent enables him to experience her as strong, powerful in herself, and concerned for his own welfare and the welfare of others. In this manner, the parent contributes to providing a realm of safety which augments the child's emotional containment.

### *Adult presence, authority and the supportive network*

Acceptance of positional authority has diminished in today's western and westernised societies. Rather than seeking a return to this more traditional form of authority, which is characterised by rigid hierarchy, emotional distance between parent or carer and child, and a much more punitive style of discipline, NVR considers adequate adult presence to be a necessary condition for parental authority of the kind that is required in today's child-raising environment. The kind of parental or carer authority that can be established today is based on the concept of "social authorization" (Omer, 2011/1). Rather than insisting on respect from the child due to the adult's position and status, this "new authority" grows from parental presence, which enables the parent to maintain emotional closeness with the child, whilst at the same time refusing to give in to controlling behaviour. The parent's authorization to take

such a position grows from within a community of supportive other adults. This community of adults encourages the parent to take a position of emotional closeness *and* to demonstrate strength of resistance to the child's demands, and validates these two sides of the parent's efforts. At the same time, this community acts as a corrective, to ensure that the parent responds to the child in a fair, non-aggressive manner. This is a radically different stance from "What happens in the family stays in the family…" – characterising a discourse which in the past has consolidated the traditional power base within patriarchal family structures.

In practical terms, parents, carers and teachers gain authority by

- committing themselves to nonviolence towards their child and to adequate emotional and physical care (as witnessed and monitored by other adults from within the wider family or community, who become part of the parents' specific NVR support network),
- refusing to give in to the child's demands,
- documenting their child's violence and informing adult supporters of aggressive incidents.
- taking direct action in response to violent or other (self) destructive incidents, such as 'the announcement' or 'sit-ins',
- asking adult supporters to witness the child's aggressive behaviour when they take action,
- asking other adults to communicate their support of the parent's resistance directly to the child,
- making serious efforts to reconcile with their child, even and especially during conflict and after having taken action,
- giving the child opportunities to show restorative behaviour and
- promoting conflict resolution through negotiation.

Parents, whose shame, depression or fear of reprisal by their child may previously have resulted in socially isolating themselves, are therapeutically supported to build up and (re)integrate themselves in a resistance-supporting social network, which can encompass relatives, friends of the family, community members, parents of other young people, school teachers and other professionals. By organising therapeutic meetings which incorporate groups of supporters in the treatment process, NVR operates as a multi-modal intervention.

## NVR and efficacy

There is a growing consensus that effective therapeutic approaches for adolescents with more serious conduct problems are systemic and multi-modal (Carr, 2009, Steiner 2004). Approaches which have met these criteria in the past have been Multi-systemic Therapy (Sheidow, Henggeler and Schoenwald 2004) and, to a degree, Functional Family Therapy (Sexton and Alexander, 2004). NVR as an approach that also meets these criteria is showing promising results.

An emerging evidence base for NVR demonstrates not only behavioural improvement in young people, but importantly also improvement in parents. In addition to behavioural improvement and an over 90% retention rate in therapy even for families of adolescents, Weinblatt and Omer (2008) found that the approach led to reduced parental helplessness, improved parent mental health and improved perception of social support in parents compared to controls. A German study compared NVR for 11-18 year old young people who were showing oppositional, aggressive and anti-social behaviour with TEEN Triple-P and a waiting list control group (Ollefs, 2009). This study demonstrated significant improvement in parental presence, improved parenting behaviour, reduced parental helplessness and reduced parental depression for both treatment groups. NVR was superior to TEEN Triple-P by

showing significant improvement in child externalising behaviour on Achenbach's CBCL. Improvement from therapy using NVR has further been demonstrated on a variety of systemic variables, which included reduced parental submission, increase in parental supervision, less dominant thinking, fewer power struggles and reduced negative emotions, as well as improvement in child behaviour (Lavi-Levavi, 2010).

In the course of the intervention, parents are introduced to a specific set of methods which lend a clear structure to the therapeutic process, and help them re-organise their responses to their child. In this manner, long established interactional patterns around violence and aggression are changed. Some of these methods are outlined below.

## Methods in Non Violent Resistance therapy

### De-escalation and parental disobedience

As punishment and controlling behaviour towards their child are likely to fuel symmetrical escalation, parents learn to become non- punitive and non-controlling. "Anti-punitiveness" has been identified as one of seven 'nonviolent personality' factors (Kool 2008; Kool and Keyes, 1990). By becoming non-punitive, parents increasingly contrast their child's aggression, and their own previous hostility, with a different kind of responsiveness, which invites the opening of new relational possibilities. Some of these possibilities are examined later in this paper in relation to developing a child focus.

Parents or carers develop a greater awareness of their own previous "automatic obedience" and are encouraged to refuse giving in to coercive demands. They practice such 'parental disobedience' at their own pace, as and when they themselves feel ready to, by

refusing to follow 'rules' stipulated by their child. They may also refuse services which have been misused by the young person. E.g., a teenage girl, who has grabbed the steering wheel of the family car and created a dangerous situation, is subsequently refused to be driven anywhere in the car, until this can be deemed safe again. In another example, parents refuse to pay off their son's drug debts any further, in spite of his threat of retaliating against them and blaming them for the risk that he might get assaulted by drug dealers. In other instances, parents may simply 'go on strike' and refuse to provide services, which would enable the young person's pleasure or recreation, such as driving him to football training (notwithstanding he can still walk there or take the bus), until there has been a successful reparation for a particular aggressive act.

Such action is carried out in a non-confrontational manner, thereby combining non-punitiveness and non-controlling responses with 'parental disobedience'. Parents learn to identify, how in the past they themselves have been insistent upon a desired response and aggressive towards their child. With therapeutic support in empathising with their child and developing an understanding of the impact of their own past controlling, punitive and aggressive communication, parents become able to develop a more respectful and caring interactional style. This promotes a parental response, which is both resistant to the child's violence *and* non-escalatory.

### *Raising parental/adult presence*

*De-escalation and delayed responses:* Self efficacy expectation is a powerful determinant of positive therapeutic outcomes (Bandura, 1997; Grawe, 1997). Parents will have been conditioned by their child's aggression to give in to his or her demands and observe 'taboos', which are articulated in the child expressing in ways such as: *"This is my house, get out of the living room"; "Shut up, I'm not listening to your crap.", "Give me that money, you..." "Don't you dare bring her (the mother's friend) into this house."* Parents' attempts to

overcome their sense of helplessness by getting confrontational will have proven futile. These parents will need to develop a greater expectation of self-efficacy, if their behaviour is no longer to be motivated by fear, shame or anger. Parental self-efficacy can increase by taking well-planned, *delayed* direct action in response to any incident of violent, destructive or threatening behaviour. Reducing risk and bringing down levels of psycho-physiological arousal – both in the child and in the parents or carers - becomes the immediate aim during an aggressive incident, whilst the actual response to the violent or otherwise destructive incident itself may take place hours or even days later. By carefully planning a decisive, yet non-escalatory, delayed response and enlisting the calming support of other adults, parents become enabled to act from a lower arousal baseline. Lower psycho-physiological arousal levels are conducive of "reasoning system" cognition, which is characterized by slow, controlled and emotionally neutral decision-making (Stanovich & West, 2000). A lower arousal level is also conducive of what has been described as 'reflective functioning' and improved 'mentalization' (Fonagy *et al*., 2004), the process of developing differentiated understanding of one's own and the other person's cognitive and emotional processes. Clinical practice using NVR shows that by taking delayed action, parents become less likely to respond with survival system reactivity, (i.e. act, think and feel as if they were responding to a threat), and instead 'step back' from their own thinking, thus becoming more aware of their own beliefs about and habitual responses towards their child. This form of psychological functioning enables greater self-control in the face of provocation. Behavioural self-control and affective self-regulation have further been identified as key psychological facets of the nonviolent personality. (Kool & Keyes, as above).

Transitional rituals can serve as markers for significant shifts in family relationships (Imber Black and Roberts, 1995). In NVR, *the initial announcement* acts as such a transitional ritual. It enables parents to break the 'taboo' against challenging the young

person's problematic behaviour, whilst at the same time expressing positive regard for him or her as a person. In this manner, the announcement becomes a marker for a shift to transitional forms of interaction which will pave the way to more peaceful and caring family relationships. In a calm and non-confrontational, but rather formal manner, parents (or other carers) tell the young person that they will no longer accept violent or destructive behaviour, express their concerns regarding these behaviours, and inform the young person that they will involve other adults in their resistance. They also hand their declaration to the young person in written form. A number of therapies informed by social constructionist ideas use 'preferred futures' to help clients develop positive goal ideation and generate hope. I have found it very helpful for parents to include their vision of a violence-free preferred future for the child and family in the announcement, serving as a built-in reconciliation gesture and reminding everyone involved that the child is not being identified with the violence.

*Sit-ins,* usually in the young person's room, are carried out hours or even days after a violent incident, to demonstrate non-acceptance of such behaviour. By challenging the young person calmly and quietly, rather than withdrawing, excluding or punishing the child, sit-ins raise adult presence. Parents or carers tell the young person they wish to hear what he or she will do to avoid becoming violent again in the future – a message indicating their expectation of greater self-control on the young person's part - , or how the young person would like to 'make up for what (they) have done' – a message indicating an expectation of the child making restorative efforts. However, parents do not insist on such a response, but wait quietly. Adult witnesses can act as a deterrent against further violence during a sit-in. As the young person is likely to try to re-establish their control with verbal or physical aggression, blaming or other responses which in the past have stimulated escalation, the sit-in becomes an arena in which parents can learn to practice emotional self-regulation. The formal structure of the sit-in supports this 'experiment' with new responses which deviate from the habitual

reactions in long-established interactional patterns. In the face of the young person's retaliatory behaviour, provocation or other attempts to 'gain the upper hand', they sit in a quietly determined manner, whilst refusing to be drawn into arguments or confrontational exchanges. Determined silence expressing parental concern becomes a powerful message that parents are unwilling to engage in any interaction other than a constructive conversation, in which the young person answers their question and shows responsibility for addressing his or her own future behaviour.

*Documentation and campaigns of concern.* Violence in relationships isolates the individuals who are being targeted, thus reducing their social support. However, social support is necessary for its protective function, social validation of the individual, to buffer stress and promote negotiation where there are tensions. There are various reasons for such isolation, such as victim shame, fear of blame or criticism, or fear of retaliation. To counteract the isolating effect of a young person's violence, parents and siblings are encouraged to document aggressive or destructive acts, give other adults access to this documentation, and ask these adult supporters to communicate their concern about the aggressive and controlling behaviour to the young person. Such *campaigns of concern* can be carried out for as long as the violence persists.

*Telephone Round and Tailing* are methods that have been developed to raise parental presence outside of the family home or school environment, especially when young people truant, come home outside of appropriate times, abscond and engage in dangerous, illegal and self-destructive behaviours when they are not directly supervised. These and the other methods outlined above have been described at length (Omer, 2004/1, as above).

## *Reconciliation*

Research into information processing in conflict situations shows that stereotypical thinking about the other and speculation about the other's (negative) intentions organises behaviour in more hostile ways (Golec and Frederico, 2004). Demonic attitudes are beliefs in a deep-seated root cause, or "essence" for problematic behaviour in the other person or in oneself Alon and Omer, 2006). The kind of reconciliation work described in this paper aims to help family members stop speculating about negative intentions in the other person, and to change their internal representations of one another. A young person, whose parent or carer persists in making reconciliation gestures, will find it much more difficult to 'hold on to' a negative internal representation of the adult. 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.

Nonviolent responses distinguish clearly between the child as a person, who remains an accepted member of the family and community, and this child's aggressive behaviour. Many parents who have had access to parenting programmes or similar interventions have learned to tell their child that they merely object to the aggression while accepting him or her as a person. However, simply *telling* a young person that they are accepted is generally not as helpful as acting in ways which are congruent with this claim. Action speaks louder than words, and by using specific *acts* of personal acceptance, adults condition themselves to become *genuinely* accepting of the child. Such congruently communicated and intrinsically felt interpersonal acceptance powerfully re-organises the parents' interaction with the child in daily life.

*Reconciliation gestures* strengthen the adult-child relationship (Omer 2004/1; 2001), by demonstrating to the child that parents, carers and teachers hold a positive image of the child in their mind, whilst at the same time resisting the violence or destructive behaviour.

NVR promotes the use of such gestures as acts of unconditional positive regard. They can therefore not be used as rewards for desired behaviour, and are persistently offered even in the face of ongoing problematic behaviour. This constitutes one of the key differences between NVR and more behaviourally oriented approaches. The adult will need to overcome any expectation that the young person should respond with gratefulness, affection or remorse for previous wrongdoings, if their gesture is to be genuinely unconditional. In other words, parents use reconciliation gestures with the aim of fundamentally improving the relationship with their child, not as a reward for desired behaviour. They need to learn to accept that the child is unlikely to show the desired response, if they are to communicate congruently that their reconciliatory moves are unconditional. Repeatedly making gestures of reconciliation, when previous ones have been refuted, will re-assure a young person of the un-conditionality of the parental response. In the relational logic of conflict, it becomes necessary to reject the parents' advance, in order to test whether they genuinely 'mean it'. This parental position of unconditionality is reflected in the Indian concept of "anasakti" (Tewari, 2000), or *detachment from the desired outcome of one's own action*. Interestingly, anasakti has been found to be associated with lower levels of aggression, and with better mental health (Pandey and Naidu, 1992). The implicit message is: "I hope this gesture will help us reconcile, but I will keep reaching out to you, no matter what you do. You are and remain my child, no matter how you respond". Such gestures can range from a small treat, such as cooking the child's favourite dish, to e.g. a highly significant apology for the parent's past failure to protect the child from abuse.

Reconciliation gestures provide an opportunity for developing a child focus within the therapeutic process. Drawing parents' attention to the whole person, rather than focussing on the aggression alone, enables them to bear alternative schemata, i.e. more positive internal representations of their child in mind, whilst at the same time resisting coercion and other

forms of controlling behaviour. Such alternative representations in turn enable the adult to become more perceptive of and responsive to their child's unmet needs.

## A Child Focus in NVR

Building on the reconciliatory nature of the approach, the author has developed a methodology for creating a child focus when practicing NVR. The theoretical underpinnings and practical methodology of a child focus within NVR are outlined in the second part of this article.

Wilson (1998), who has articulated the need for raising a child focus in family therapy, builds on the metaphor of 'voice' in addressing children's contributions to their own therapeutic process. Key to making space for the voice of the child is to talk "...*with (as opposed to about) children* ..." (as above, p.3). Whilst encouraging therapists to talk with children, even when they act in controlling ways, Wilson does not advocate becoming *"...sanctimonious about children's rights": "How often as therapists have we wanted to escape the difficulty of talking to a child who is omnipotently trying to control parents and shout down everyone else's opinion. In these situations it is difficult to think of the child's voice being 'marginalized'!....In fact, to work in this way requires a therapist to be robust sometimes, helping to find more useful ways for children to bring new meaning to their actions, including struggling to make a connection with the possible meanings in their anger, outrage or distress. Collaborative styles of practice suggest that the therapist's job is to offer a link between these different accounts and to raise the child's* ***other*** *voices where these have become muted, turning the volume up without droning out the parents."* (as above, p.4, emphasis added)

Several questions arise in the context of child focus: Is it therapeutically desirable for NVR to develop a greater child focus? Can NVR – an approach in which the therapist works with parents, other adults and siblings to resist a young person's aggression - be child focused? How do we need to adapt our methodology, if NVR is to increase its child focus? Some answers derived from my clinical work in so-called 'complex cases', i.e. work with multi-stressed families and with looked-after children, who have experienced trauma and child abuse, are presented in the following part of this article.

Before addressing a focus on the *violent* child in the family, it is important to note that a dominant discourse in our society, which presumes childhood innocence, detracts from professionals' and families' awareness of serious sibling violence and abuse (Kettry & Emery, 2006). By seeing a violent child's sibling alone, in the protected environment of the therapy room, by witnessing their account of victimisation, by inviting them to document the violence that is perpetrated against them, and by encouraging them to share their documentation with a trusted adult who will use this information in a protective way (Omer *et al*., 2008), the nonviolent methodology literally centres the muted voice of the victimised child in the family within therapeutic conversation.

Wilson (above) appears to be referring to 'other voices' within the dominant child, which perhaps have been obscured by anger and are no longer expressed or listened to by significant others – or by the child him- or herself.

Newman and Nolas (2008) have examined the question, whether NVR can be child focussed. Newman's research of the NVR literature identifies very different constructs of the "violent child". These relate to two different discourses. In the 'war' discourse, the violent child is seen as a perpetrator who has power, and acts as a strategist, occupier and ruler. However,

Newman also identifies a 'family values' discourse in Omer's writings on NVR, which characterises the aggressive child as having positive qualities, requiring love and guidance, needing to be loved by the parents, deserving of respect, and having positive 'internal voices' which can be strengthened. In highlighting the 'voice' metaphor, which is used in similar ways by both Wilson and Omer, Newman points to the possibility of developing a greater child focus within NVR. While Omer sees the strengthening of the violent child's positive internal voices as a process of becoming reconciled with their parents and adopting kinder and more caring attitudes, Wilson draws attention to the unheard voice of distress in the young person, a voice which has been 'all but droned out' by anger, controlling and destructive behaviour. It will be argued here that the 'voice of distress' can be given more conversational space in therapy through the process of reconciliation work. This argument will begin with an examination of constraints to parental care, to be followed by a description of unmet needs in young people who act in aggressive and controlling ways, and finally an introduction to the methodology of using reconciliation work to address unmet child need.

Constraints which inhibit parental care responses can be located both in the parent's and in the child's experience of one another and of the self. The answer to developing a greater child focus within NVR can be seen in overcoming such constraints by helping parents (re) sensitize themselves to their child's needs.

## Constraints to adult care responses

### *Adult experience of the controlling young person*

Aggressive behaviour in children tends to become part of a self-perpetuating negative cycle of interaction (Linares *et al*., 2006). Parents and carers of children who act violently tend to show high levels of psycho-physiological arousal. Certain key behaviours of their child

become triggers for rapid and powerful emotional responses. Parents often indicate that they have developed greater threat awareness when they are around their child. It is easy to see how the so easily aroused self-protective emotions – anger and anxiety - , distract adults from being alert and sensitive to distress signals from the angry child.

It has been demonstrated that foster carers' initially nurturing behaviour gives way to non-nurturing, more punitive care when children act dismissively, as if they did not need the carers to meet their needs (Dozier *et al*., 2002).

Parents typically express a very limited awareness of any of their angry child's distress. They frequently describe how they physically avoid being in the presence of their child. Parents also tend to avoid being internally aware of their aggressive child, even when the young person is physically present: "I just switch off; I try to distract myself and not to think about him, even when he's there; I wouldn't be able to function otherwise".

Angry child behaviour can even trigger serious post-traumatic stress in some parents. Clinical experience shows that this is especially common in families with complex therapeutic needs and long histories of exposure to trauma, so-called 'multi-stressed' families. Intrusive memories of previous trauma (often domestic violence perpetrated by an adult male), flashbacks, and dissociation (e.g. feeling completely void of emotion, or 'spaced out'), can occur in the wake of violent or threatening child behaviour. Anxiety, intrusive symptoms or emotional numbing will make parents less perceptive of any indicators for unmet need in their child.

Prolonged trauma and abuse have been associated with depression (Shalev et.al., 1998). Learned helplessness is a widely accepted psychological model of depression (Seligman and Maier, 1993). Helplessness depression is linked to a certain style of attribution: individuals tend to attribute negative events to causes internal to them, in a stable and global way. Domestic violence has been described as a context that generates learned

helplessness (Walker, 1977; Peterson and Seligman, 1983). Negative, self-directed attribution regarding the aggressive behaviour of their children can be observed in the often very depressed parents of aggressive young people, who have experienced domestic violence. Such parents often think of themselves as inept, believing that their supposed lack of parenting ability has caused the presenting difficulties. Parent-blaming discourses among professionals, in the wider family, among friends and in society at large tend to reinforce self-blame among parents (Jackson and Mannix, 2004). Self-blaming processes are especially prevalent among parents who have developed a strong sense of helplessness, and who attribute their child's violent behaviour to negative causes in themselves. Such negative, self-focused thinking conspires with low mood, lowered energy levels and a reduced sense of self-efficacy to distract parents from recognising their child's needs and inhibit their caring responses.

Mutual negative attributions develop between parents and adolescents in conflictual relationships (Grace *et al*., 1993). Parents often hold negative internal representations of the child, and as a result adhere to the belief that they can expect little else than problem behaviour. They describe how they attribute many of their child's behaviours to the notion of a deep-seated, negative core personality, which is often assumed to be un-childlike. Such a 'psycho-demonic view' (Alon and Omer, 2006) leads to further 'destructive fighting' between parent and child, and parents become even less aware of their child's unmet needs: "When he makes that face, I see his father in his eyes, all the evil in him; he's like a carbon copy of him". Asked whether she experiences her son as an adult or as a child, when she thinks of him in this way, a mother answers: "He's not like a child, he is evil". Parents do not show caring responses to the perceived needs of an 'evil adult' in the same manner as they do to perceived 'child' needs.

### *The young person's internal and behavioural response to their own unmet need*

High levels of anxiety in conjunction with hyperarousal of the amygdala have been found to be associated with an increased interpretation of risk in a person's environment (Vasterling and Brewin, 2005). Amygdala hyperarousal is associated with traumatic experience and threat responses. Boys with early onset conduct disorders have been found to show hyperarousal of the amygdala (Herpertz et al, 2008). Ohman (2005) found that young people with behaviour problems show greater activation of the amygdala, and react more aggressively than others when they are presented with learned threat or even with neutral stimuli. There are many similarities in the way anxious children and aggressive children experience perceived threat. E.g., anxious and aggressive children alike are more likely than others to interpret ambiguous stimuli as threatening (Barrett et al, 1996). The difference is that anxious children choose avoidant strategies to deal with the perceived threat, while oppositional children choose aggressive ones. Interestingly, Barrett et al also found that discussions about the perceived threat within the children's families further enhanced these respective strategies. Aggressive children interpret social information as more hostile, and report that they are more likely to respond with aggression to the social behaviours they have perceived as hostile (Quiggle *et al*, 1992).

The above research paints of picture of aggressive young people who inhabit a threatening world. Unlike anxious children, who also live in such a threatening world, and who choose to avoid what frightens them, aggressive children appear to feel they must attack, in order to gain superiority and control their environment. Perceiving their social environment as threatening, aggressive young people are unlikely to confide any discomfort or distress in the very people they see as hostile. Feeling angry and going on the attack, they will not

experience their own distress clearly, or for any significant length of time. Using Fonagy's terminology, the activation of the survival system will inhibit mentalization, or the process of identifying one's own cognition and emotion in relation to another person. Showing survival system reactivity, it is likely that reduced mentalization inhibits angry young people from *identifying distress clearly within themselves,* and communicating emotions and thoughts associated with distress to their significant others. As a result, many of their needs remain unattended.

Interpersonal problems with peers or family result from aggressive behaviour, and are often associated with depression in young people with conduct problems (Patterson and Stoolmiller, 1991). When the behaviour of controlling young people alienates significant others and leads to interpersonal rejection, they find it difficult to feel a sense of belonging within the family, community, school and among peers. Unsurprisingly, many young people with controlling behaviour tell us that "all (their parents) do is shout"; that "they don't care how (the young person) feel(s)". Often, they speak of not liking their family, not belonging, feeling they have been born into the wrong family, or believing others in the family wish they weren't there. Young people are less likely to signal the need for care, when they do not feel a sufficiently strong sense of belonging within their family, school and community.

The logic of control - I must control in order to avoid being controlled – makes it difficult for young people to feel they *receive* any caring responses from their parents. By pressurising her parents to fulfil her wishes, in effect, the young person has come to rely on self-gratification, no longer experiencing the caring responses that unconditionally loving parents show without any pressure.

## Unmet Child Needs

The patterns of interaction which inhibit need-focused communication between parent and child lead to significant areas of unmet need in young people with serious conduct problems. Some of the most common areas of unmet need, as they emerge in clinical practice, are examined below.

### *The need to feel safe and protected*

*Attachment and security:* If the environment one lives in is perceived as hostile, one does not feel safe and cared for. Experiencing the family environment and other social contexts as hostile, whilst at the same time being faced with parental helplessness and inconsistency, it will be difficult for aggressive children to feel protected. Attachment theory implicates negative expectations arising from the child's internal working model of the parent -child relationship in the failure to feel safe and emotionally contained. Historically, attachment theorists have paid much attention to early parent-child interaction. A systemic perspective, which is concerned with interaction in the here-and-now, points to how raising parental presence can help transform child expectations and allow the young person to feel more securely attached by experiencing parental strength (Omer and von Schlippe, 2011). By (re)sensitising themselves to their child's needs, parents can become more attuned and emotionally responsive to their child, model emotional self-containment, and eventually provide a greater sense of security.

*Post-traumatic stress:* Many children from multi-stressed families have had intensely traumatic experiences, such as being subjected to child abuse or witnessing domestic violence over prolonged periods of time. Often, these young people experience symptoms of post-traumatic stress, which concur with their aggression. Trauma survivors require very specific

responses from significant others to support their recovery, enabling them to develop a subjective sense of safety (Herman, 1992). Violent and aggressive young people will need to perceive significant others as available and protective, without becoming over-protective, if the family is to help them develop a subjective sense of safety. The family can thereby become a key resilience factor by acting as a recovery environment (Madsen, 2007).

*Anxiety:* A number of young people with difficulties relating to anxiety, such as social-anxiety driven self-isolation or OCD-type behaviour, control their family environment in order to avoid exposure to anxiety-provoking situations. These young people, many of whom may show features of an autistic spectrum 'disorder', have a need for their parents to provide emotional containment and support positive self-directed beliefs in their child, whilst at the same time challenging the young person to engage with situations which they have avoided so far.

In other cases, even where there have been few or no pre-existing difficulties relating to anxiety, controlling behaviour enables aggressive young people to avoid normative life-stage challenges, for which they need to develop competencies. E.g., competition among peers, difficult academic performance challenges, or the need to resolve conflict by negotiation are avoided, when a young person is excluded from school for aggressive behaviour, or refuses school attendance. Young people who find it difficult to learn to communicate their romantic and sexual needs appropriately, may avoid this by withdrawing from specific social situations such as school or work, changing their peer affiliation, or by developing an insensitive, harmfully intrusive and controlling sexual style of interaction with vulnerable children and young people. Many intellectual and psycho-social competencies need to be developed rapidly in the course of adolescence. By missing out on such learning experiences, young people with controlling behaviour experience lower self-confidence because of their lack of necessary competencies. This in turn raises anxiety levels, and makes

it more likely for young people to further avoid low-competence experiences by controlling their environment, resulting in a vicious cycle (see illustration 1). Young people, whose anxiety has grown as a result of their controlling behaviour, need parents, carers and teachers to recognise areas in which they do not feel confident and to support their performance in these areas. In order to communicate a strong expectation and belief that they will succeed, adults need to recognise strengths and potential resources within the young person.

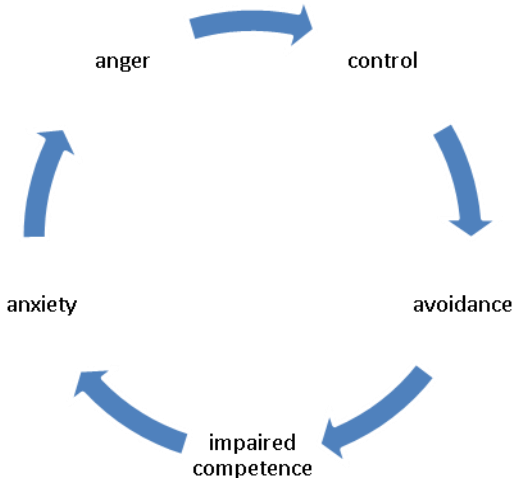


Illustration 1: control/anxiety cycle

## *The need for support in one's development*

Various transitional phases in the child's and family's life cycle, such as moving home, school-age, secondary school, puberty, divorce and separation of parents, birth of another child, forming a re-constituted family, illness, death, etc. create stressors that affect the psychological functioning and emotional wellbeing of each family member (McGoldrick and Carter, 2003). Normal family processes include daily acts of support by parents and other

family members, by which young people are encouraged, validated, advised, guided and inspired in meeting their developmental challenges, especially at such transitional phases in the family life cycle.

An important function of normal family process is for parents or carers to provide emotional containment in stressful transitional periods. Parents need to be empathic and compassionate, whilst practicing emotional self-regulation. In this way, they provide a learning environment for the young person to develop emotional self-regulation in their own right. When children struggle with special developmental difficulties such as social communication disorders, ADHD, learning difficulties etc., there is an even greater need for supportive parental care responses that are woven into everyday interaction between parent and child.

### *The need to feel a sense of belonging*

Adolescents and children need to have a strong sense of belonging to their birth family, kinship network, school, peer-group, neighbourhood and wider community, if they are not to feel lonesome and deprived of intimacy. They require this sense of belonging in order to access interpersonal resources – significant others who can encourage, support, validate and guide a young person through periods of developmental transition. Fractured family histories, and the fallout from their own aggression, can leave young people with a weak sense of belonging.

A rapidly forming sense of self and personal identity in adolescence depends on group membership. Inclusive responses by others within the various important social contexts they inhabit help young people to establish their own identity.

### *The need for a coherent and benign narrative of self and family*

We locate how we perceive ourselves and others within multiple accounts of ourselves and the social groupings we belong to (Gergen, 1991). Such narratives of 'self- and other' organise our perception and form the background against which we evaluate our own actions and those of others. These narratives, which ultimately represent reality as we see it, are in turn influenced by discursive practices, i.e. the kinds of stories that are told about life in various cultures, societies, groups and families.

The coherence of previously existing stories and their content of positive descriptions may be insufficient in the families of violent young people. Often, family histories shaped by events such as intra-familial violence and abuse, family schism, war, migration and discrimination will lead to stories which are fragmented. Story-stem research (Hodges and Steele, 2000) has shown that looked-after children with 'disorganised attachment' produce more fragmented stories. Steele et al (1996, 2003) have found that even parents with adverse attachment histories are more likely to have securely attached children of their own, if they are able to create an emotionally coherent account of their own childhood adversity, which includes someone they can associate as a strong and benign parental figure. 'High self-reflective functioning' in these parents with adverse histories goes hand-in-hand with an integration of positive and negative experiences in the parents' accounts.

Conflict and distress narratives of boys with behaviour problems have been shown to be much more aggressive than those of controls (e.g. Hill *et al*., 2007). A recent study which focused on *distress* narratives in children from 4 – 11 years of age (Wan and Green, 2010), found that a number a-typical themes differentiated those with 'clinical level' behaviour problems from others. These themes were maternal injury, maternal sadness and 'role reversal', in which the child takes on a parental role, e.g. by showing pre-occupation with or caring for the mother. Whilst it is unfortunate that much of the story-stem research focuses on

the mother-child dyad alone, it appears to be a safe inference that these children did not perceive their parent as a source of comfort, containment or protection when experiencing distress.

When a coherent narrative of family includes sufficient positive descriptions of other family members and of ourselves, our relationships with significant others can become a source of psychological wellbeing. Re-storying (Epston *et al*., 1992) the histories of parents' and children's lives can enable young people to develop a stronger and more reliable sense of identity, feel that they are cared about, and experience themselves as valuable persons who deserve care. Recent attachment-based systemic approaches consider it important to help family members alter their attachment narratives (Dallos and Vetere, 2009).

## Reconciliation work to address children's previously unmet needs

Planning and delivering gestures of reconciliation can be utilised as a goal-directed, structured process to help family members develop transitional patterns of interaction and overcome negative internalisations of each other.

Better than words, an unconditional gesture of reconciliation can reassure a child, that any action the parents take because of his recent violent or self-destructive behaviour is not directed against him as a person. Beyond this purpose however, each reconciliation gesture provides parents with an opportunity to communicate their awareness of the child's unmet need. A reconciliation gesture's ambiguous nature allows parents to signal their willingness to respond in a care-giving manner, without the young person needing to validate or accept the parents' effort.

In the therapy session, planning a reconciliation gesture can be used to help parents focus on and develop a greater internal awareness of their child's unmet and poorly communicated needs, become more empathic and subsequently containing of the child. A few methods, which can help create conversational space for unmet child needs are outlined below.

*Need-focused question sequences.* It is helpful to draw the parents' attention to the fact that their child is likely to feel and express anger, rather than having a strong sense of their own distress and communicating this. Question sequences such as the following can be a useful therapeutic tool:

> *"If he hadn't got angry and aggressive after school yesterday, what other thoughts and emotions do you believe Jack would have expressed?"*
>
> *"How have you known this has been going on at school?"*
>
> *"How were you able to sense that that was what he was struggling with?"*
>
> *"How did you become alert to his distress, in spite of Jack's anger?"*
>
> *"What small gesture could you make, that would show him you understand his distress? And at the same time save his face? Take your time to think about what the gesture could look like. You know so much about Jack, and what would help him feel understood."*
>
> *"OK, so when you make that gesture - what will help you avoid the trap of expecting a positive response from him, so that your gesture is truly unconditional?"*

*Interviewing the internalised other* (Tomm, 1998) is a technique that can be used to support the development of empathy. Parents are asked to answer the therapist's questions from the perspective of their own (aggressive) child's difficult feelings. The therapist can then proceed to ask the 'internalised child' about his or her discomfort or distress, the preferred parental

response to their need, and what effects such a parental response might have. After this role play, parents can plan a reconciliation gesture based on the 'internalised child's' preferred parental response.

*Visualisation.* Schwarz (2002) uses a visualisation-merging technique to help clients with complex PTSD overcome so-called 'splitting', or either/or internalisations of other people. This technique can also be helpful to keep parents cognitively and emotionally in touch with their child's unmet need. The parent can be asked to draw or sculpt their internal image of their controlling child. They then draw or sculpt an internal image of their child in distress. The parent then superimposes one image onto the other in their mind, allowing the two images to merge, and then draws or sculpts the merged image. This new, merged image can be brought to mind by the parent, when they plan a practical gesture of reconciliation in the therapy session.

*Therapeutic network meetings.* Where a young person has a generally supportive relationship with a trusted adult, such as an individual therapist, mentor, adult family friend or relative, this person can act as the child's 'voice' in articulating unmet need. After negotiating with the child what should be passed on to the parents, the trusted adult can impart information about the child's distress. A therapist can utilise this to help re-focus the parent's attention on their child's unmet needs. A useful modality for this kind of conversation is the therapeutic network meeting, which is facilitated by the NVR therapist. These meetings involve the parent(s), the young person's 'trusted adult', other adult supporters and professionals. In subsequent sessions, the therapist supports parents in developing reconciliation gestures, which can signal their awareness of the child's distress, and their willingness to provide care.

## Case Vignette

*Max, his mother Jill and his two sisters were no longer living with the children's father, who had been violent towards the children, and had sexually abused their mother from her childhood onward. In the past, Max' father had beaten him and his sisters in the presence of their mother, who remained passive in the face of this abuse. Max believed that his mother had failed to protect him from his father out of indifference to his suffering. In this narrative, she could not love him, as she had not protected him; hence, he was not a loveable child, he was a 'bad person'. He also felt that he had to look after his own needs, as his mother would not. The means by which he 'looked after himself' involved acting violently within the family.*

*Max was bullied at school. Initially, when Max would come home angry from school and verbally abuse his mother and younger sister, Jill would escalate verbally along with him in a symmetrical pattern. When Max' threatening behaviour or physical violence reached a certain threshold, Jill would become dissociative in response. E.g., she would wrap her arms around herself and rock back and forth, humming to herself, as she had done in the past, when she had been assaulted by Max' father. At this point, a cycle of complementary escalation would ensue, with Jill giving in to Max' increasingly unreasonable demands. Jill and her children did not speak about the family history of abuse, and Jill was very anxious that such conversations could lead to the disclosure of the family secret, i.e. her experience of sexual abuse by the children's father.*

*Not speaking about the abuse history left the family narrative fragmented. E.g., Max did not know that Jill had experienced post-traumatic dissociation in the past, when his father used to hit* ***him****, a passive response that is markedly different to one borne out of indifference. He also did not know about the ways in which Jill had attempted to protect her children. Max had also developed a view of his mother as 'weak'. Conversely, Jill had little*

*awareness of Max' need of protection and had come to identify him with his father due to his aggressive responses.*

*Jill started de-escalating during Max' violent outbursts, by walking away early on during any aggressive incident. 'Walking away' can contain many different messages; de-escalation is an internal psychological process as well as a physical act, and Jill's successful attempts at de-escalation were supported by a growing awareness of unmet need in Max. Bearing Max' distress in mind, whilst at the same time reminding herself that she was able to take resistant action later, Jill eventually became able to walk away in a manner that was neither anxious nor angry or rejecting, but actually calm, while firmly opposing any unproductive communication. She raised her parental presence by asking friends of the family to express their concerns to him, whenever Max had acted in a physically violent way, and by carrying out sit-ins in Max' room with the help of adult supporters.*

*Jill felt less helpless as a result of being able to take such action. Max had given his individual therapist permission to share his problematic narrative of the family's history in therapeutic network meetings. Jill's increasing sensitisation to Max' unmet need was further augmented with 'interviews with her internalised child' in subsequent therapy sessions. Jill used the information about his fragmented, incomplete and negative understanding of the family's history and their parent-child relationship to plan reconciliation gestures. These gestures indicated her awareness of Max' need to feel cared for by his mother, his need for more positive beliefs about himself, and his need to experience his mother as strong. Hence, the gestures Jill developed aimed to communicate her care for her son, and her developing efficacy in everyday life. These efforts were guided by the assumption, that by experiencing his mother as both 'strong' – because she was able to resist his controlling and violent behaviour – and at the same time 'caring', Max would be able to develop an internal representation of his mother as a protective parent, and a self-representation of a child who*

*is worthy of such protection. She started showing him she cares about him with small, careful gestures of physical affection, and by using little notes to tell him that she was thinking of him when he was at school. Max began signalling some of his distress when, instead of "kicking off" after coming home angrily from school, he went to his room and contained his anger, and later told his mother about that day's incident of bullying at school. This gave his mother the opportunity to act in a protective manner, by going to the school on his behalf and discussing solutions to the bullying problem with Max' Head of Year teacher.*

*At a later point, Jill began telling Max more details about her responses to the father's past violence, some of which were protective of the children; e.g., Max' father used to lock the children in their rooms, and she would liberate the children from their rooms once the father was asleep and look after their needs. Max realised that his mother had protected him as she best could. He also realised that the reason for her past inability to confront the father face-to-face lay in her fear and sense of helplessness, rather than indifference. Withoug having been told about this, Max also inferred that his mother had been sexually abused by his father prior to his birth. While the frequency and severity of violent incidents had already dropped considerably following the de-escalation, sit-ins and repeated expressions of concern, his physically violent and verbally abusive behaviour abated completely in the wake of the reconciliation work. Whilst his mother no longer perceived Max as the embodiment of his father's abusiveness and had developed a growing awareness of his needs, the shift in the family narrative also became apparent in Max' individual therapy sessions, where he referred to his mother's strengths with an increasing sense of pride. These changes have remained stable for approx. two years.*

## Conclusions

Many children and adolescents with serious conduct problems show little self awareness of distress; they do not communicate distress clearly, readily converting difficult feelings into anger. Parents become less aware of their child's unmet needs, such as the need to feel safe and protected, the need to feel a sense of belonging, the need for support in one's development, and the need for a coherent and sufficiently benign narrative of self and family. Parents can raise their own awareness of the child's potential for distress, and increase their caring presence, by using reconciliation gestures that communicate willingness to address unmet need in the child. This complements other ways of raising parental presence in NVR, e.g. when parents challenge aggressive and controlling behaviour by using sit-ins in the child's room, or initiate campaigns of concern. Clinical experience suggests strongly that incorporating this kind of child focussed work within NVR can help to foment the therapeutic process and consolidate therapeutic gains, especially in families with multiple stressors and histories of abuse. Whilst a promising evidence base for NVR therapy is currently emerging, future systematic research may support the clinical view that child-focused reconciliation work gives added value to therapy, especially in multi-stressed families.

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